

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10147

Reg. Dist. No. 223

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County... Montgomery

City or town... Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months + 16 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium + Hospital

How long in hospital or institution? 3 months + 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... District of Columbia County

City or town... Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No... 3804 Windsor Pl. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

Hcock, Mr. Frederick W.

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mrs. Ethel L. Hcock

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1880 6(c) If alive, give age years

8. AGE: Years Months Days If less than one day
67 9 4 hrs. min.9. Birthplace London, England
(Town, county, and state)

10. Usual occupation Architect

11. Industry or business State Dept. U.S. H.

12. Name George Thomas Hcock

13. Birthplace England

14. Maiden name Harriet Woodfield

15. Birthplace England

16. Informant Washington San. + Hosp. Records

Address Takoma Park, Maryland

17. Burial, cremation, or removal, which? Cremation Date thereof 11-29-47
(month) (day) (year)

Cemetery or crematory

Location Washington, D.C.

18. Funeral director The D. & F. Service Co.

Address 2901-14th St. N.W. 3rd flr.

19. Date rec'd by registrar Nov. 29 1947

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1947 at 7:12 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1946 19 to Nov. 29 1947

and that I last saw him alive on Nov. 28 1947

Immediate cause of death

Diabetic Gangrene

Due to Arterosclerosis

Due to Diabetes Mellitus

Other conditions Pericarditis

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Confirm above Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

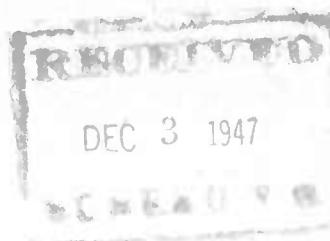
Means of injury

Injured at work?

23. SIGNATURE Robert A. Hare M.D.

M. D. or other

Address Takoma Park, Md. Date signed 11/29/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

16148

CERTIFICATE OF DEATH

93d
216

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 12 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?..... 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md. County..... PG

City or town..... College Park

(If outside city or town limits, write RURAL and give nearest town)

Street No..... c/o H. M. Marlow

(If rural, give LOCATION)

2.(a) If veteran, name war..... WW I

3.(a) FULL NAME

ADAMS, Walter Thomas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo. day. yr.) December 12, 1893

8. AGE: Years	Months	Days	If less than one day
53	11	10	hrs. min.

9. Birthplace..... Md. (Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business

12. Name..... ADAMS, John T. dec.

13. Birthplace..... Md.

14. Maiden name..... WALKER, Mary Jane dec.

15. Birthplace..... Md.

16. Informant..... sister: Mrs. Annie Lee

Address..... College Park, Md.

17. burial Date thereof..... 12-26-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Good Hope

Location..... Colesville, Md.

18. Funeral director..... SNOWDEN Funeral Home

Address..... Rockville, Md.

11-24 47

(Date rec'd by registrar)

Mary C. Patterson
Mary C. Patterson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 22 1947, at 9:56 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 10 1947, to November 22, 1947,

and that I last saw h. in alive on 22 November 1947

Immediate cause of death..... Congenital heart

failure

Due to..... H. Systemic heart

failure

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results..... Confirm alone

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work? 102 Bellmore 8/33

D. E. BILLMAN, Lt. JG MC USN

M. D. or other..... 11-24-47

Address..... USNH Bethesda, Md. Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death, write the causes of death clearly and legibly. It is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10149

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda, (rural)

(If outside city or town limits, write RURAL and give nearest town)

9 days

How long in above place of death?

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or Institution?

9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C. County.....

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 509 3rd St., N.W.

(If rural, give LOCATION)

WWI

2.(a) If veteran, name war.....

3. (a) FULL NAME

ALGATE, Roy Tarry

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

March 31, 1881

8.(c) If alive, give age years

8. AGE: Years	Months	Days	If less than one day
66	7	24	hrs. min.

9. Birthplace..... N.Y. (Town, county, and state)

10. Usual occupation..... Retired Govt. Employee

11. Industry or business

12. Name..... ALGATE, John R. dec.

13. Birthplace..... Eng.

14. Maiden name..... DAMON, Harriett Ann dec.

15. Birthplace..... N.Y.

16. Informant..... brother: Mr. Stanley W. Algate

Address..... 509 3rd St., N.W., Wash., D.C.

17. burial Date thereof..... burial

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington National

Location..... Arlington, Va.

18. Funeral director..... W. W. CHAMBERS

Address..... 1400 Chapin St., N.W., Wash., D.C.

19. 11-25-147 Mary C. Patterson

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 25 1947 at 1 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 Nov. 1947 to 25 Nov. 1947

and that I last saw h. im. alive on 25 Nov. 1947

Immediate cause of death..... Coronary thrombosis

Pulmonary infarction

Due to..... Venous thrombosis,

femoral

Due to.....

Other conditions..... arteriosclerosis

nephrosclerosis & lithiasis

(Include pregnancy within 3 months of death) Hypertension

5/15. t

Major findings of operations.....

Autopsy results..... Coronary thrombosis - pulm. infarct

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... J.E. Neely

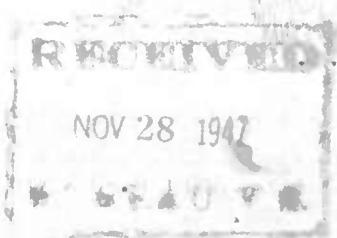
Injured at work?

23. SIGNATURE..... F. E. WETZEL, Lt. MC USN

M. D. or other

Address..... USNH Bethesda, Md.

Date signed..... 11-25-47



RECORDED

NOV 28 1947

SEARCHED INDEXED
SERIALIZED FILED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use the correct age. Is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10152

214

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

10 MINUTES Street address where death occurred:

703 Richmond Ave.

How long in hospital or institution?

3. (a) FULL NAME

George B. Bailey

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Eva

6.(c) If alive, give age years

7. Birth date of deceased (mo. day. yr.)

Aug. 18th. 1903

8. AGE:

Years
44Months
3Days
11

If less than one day

hrs.

min.

9. Birthplace.....

St. Marys, Md.

(Town, county, and state)

10. Usual occupation.....

Clerk - U. S. Goverment

11. Industry or business

MOTHER FATHER

12. Name..... William A. Bailey

13. Birthplace..... Maryland

MOTHER FATHER

14. Maiden name..... Martha Combs

MOTHER FATHER

15. Birthplace..... Maryland

16. Informant.....

Mrs. Eva Bailey

Address 703 Richmond Ave. Silver Spring

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof 12-2-1947

(month) (day) (year)

Cemetery or location Cedar Hill

Location Suitland, Prince Georges Co. Md.

18. Funeral director.....

Wm. E. Kumpf

Address

Silver Spring, Md.

19. nov. 29

19. 47 Josephine M. Schaeffer

(Date rec'd by registrar)

Reg. No.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Montgomery

City or town..... Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 703 Richmond Ave.

(If rural, give LOCATION)

2.(o) If veteran, name war..... no

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2 29 1947 at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Def med. Eric case

and that I last saw h..... alive on 19..... to 19.....

Immediate cause of death.....

Coronary occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury.....

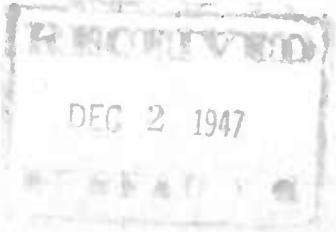
Injured at work?

23. SIGNATURE.....

Frank J. Grosshart M.D.

Def med. Eric M. D. or other

Last place living M.D. Date signed 1-1-29



PLEASE WRITE IN PENCIL, WITH UNFADEING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1258

10150

216

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Montgomery

Bethesda (rural)

City or town..... (If outside city or town limits, write RURAL and give nearest town)

26 days

How long in above place of death?

Hospital, Institution, or street address where death occurred:

U. S. NAVAL HOSPITAL, Bethesda, Md.

26 days

How long in hospital or institution?

3. (a) FULL NAME

BALL, Marie Anastosia

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female W-US married

James E. Ball

6. (b) Name of husband or wife.....

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29, 1911

8. AGE: Years Months Days If less than one day hrs. min.

36 6 6

9. Birthplace..... Texas (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business.....

12. Name..... HOSEK, Tom

13. Birthplace..... Czechoslovakia

14. Maiden name..... ANASTOSIA, ?

15. Birthplace..... Czechoslovakia

16. Informant..... husband: James E. Ball, CRM USN

Address..... 1308 Fairmont St., Washington, D. C.

17. Burial..... Date thereof.....

(Burial, cremation, or removal: Which?) (month) (day) (year)

Cemetery or crematory..... Hollywood

Location..... Houston, Texas

18. Funeral director..... Warner Pumphrey, 8434 Georgia Ave.

Address..... Silver Springs, Md.

19. (Part used by registrar) Mary C. Patterson

Mary C. Patterson

Registrat

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town..... Washington, D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1308

Fairmont Street, N. W.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 5 1947 at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 9, 1947, to November 5, 1947, and that I last saw her alive on November 5, 1947.

Immediate cause of death..... *Hemorrhage*
2 Accidents

DURATION

3 days

Due to..... *Acute Hepatitis c*
Cholangitis

2 months

Due to..... *Untraured*

Other conditions..... (Include pregnancy within 3 months of death)

Major findings or operations..... Date of op.....

Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... C. C. Matson M. D. or other

Address..... USNH Bethesda, Md. Date signed..... 11-6-47

~~RECORDED~~

NOV 8 1947

BUREAU ♀

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 714

131a 10153

1. PLACE OF DEATH:
Montgomery
County.....

City or town..... Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

~~Hospital~~ ~~Kemp Mill Rd.~~ street address where death occurred:
Gray Rd. near Kemp Mill Rd.

How long in hospital or institution?

3. (a) FULL NAME
SILAS EUGENE BEAN

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	married

6. (b) Name of husband or wife..... Valma Cornwall

7. Birth date of deceased (mo., day, yr.) Aug. 14th. 1888

8. AGE:	Years	Months	Days	If less than one day
	69	2	26	hrs. min.

9. Birthplace..... Colesville, Maryland
(Town, county, and state)

10. Usual occupation..... Retired Farmer

11. Industry or business

FATHER	12. Name..... John Asbury Bean
	13. Birthplace..... Maryland

MOTHER	14. Maiden name..... Margaret Ellen Barnes
	15. Birthplace..... D. C.

18. Informant..... Silas E. Bean, Jr.

Address..... Kemp Mill Rd. Silver Spring

17. Burial..... Date thereof 11/13/1947
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... St. Johns

Location..... Forset Glen, Montg. Co. Md.

18. Funeral director..... Warner E. Pennington
Address..... Silver Spring, Md.

19. Nov. 17 1947 Josephine Dehaeger
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Montgomery
City or town..... Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No..... Grsy Rd. near Kemp Mill Rd.
(If rural, give LOCATION)
no

2.(a) If veteran, name war.....

3. (b) Social Security Number
none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 10 1947 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JUNE 8 1947 to NOV 10 1947
and that I last saw h.m. alive on NOV 8 1947

Immediate cause of death..... Gremic Coma
DURATION 2+ days

Due to..... Arteriosclerotic Kidney disease
DAYS 2 yrs.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... None
Date of op.....

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... No Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... M. D. or other
Address..... Silver Spring, Md. Date signed 11/10/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10155

714

CERTIFICATE OF DEATH

82
Reg. Dist. No.

1. PLACE OF DEATH:

County Montgomery

City or town Ednor

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

3. (a) FULL NAME

Florence Miller Bond

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female

white

Married

B (b) Name of husband or wife Charles E.

7. Birth date of decease (mo., day, yr.)

Nov. 23rd. 1873

8. AGE:

Years

Months

Days

If less than one day

74

0

3

hrs.

min.

9. Birthplace Sandy Spring, Md.

(Town, county, and state)

10. Usual occupation Retired Housewife

11. Industry or business

MOTHER FATHER 12. Name Robert B. Stabler

13. Birthplace Maryland

14. Maiden name Anna B. Taylor

15. Birthplace Virginia

16. Informant Mr. Charles E. Bond

Address Ednor, Montg. C. Md.

17. Cremation

(Burial, cremation, or removal. Which?) Date thereof 11/28/47

(month) (day) (year)

Cemetery or crematory Cedar Hill

Location Suitland, Pr. Geo's Co. Md.

18. Funeral director Barnes & Penphrey

Address Silver Spring, Md.

19. Nov. 27, 1947 (Date rec'd by registrar) J. Langford Schaeffer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Montgomery

City or town Ednor

Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(o) IF VETERAN, NAME WAR no

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

11-26

1947, af P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

11-5-1947 to 11-26-1947

and that I last saw her alive on 11-24-1947

Immediate cause of death

Pneumonia, Hypostatic

DURATION

1 day

Due to Pharyngeal Abscess

2 days

Due to

Other conditions Senile Myelitis +
Tic douloureux

7 to 9 yrs.

Tic douloureux (Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 900 Georgia Ave.

Date signed 11-27-47

RECORDED

DEC 2 1947

SEARCHED INDEXED
SERIALIZED FILED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10154

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County... Montgomery

City or town... Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

9412 St. Andrews Way

How long in hospital or institution?

3. (a) FULL NAME

Ella Marie Boote

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female white married

6. (b) Name of husband ~~xxx~~ Ward E. Boote

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1898 6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
49 9 7 hrs. min.9. Birthplace... Laceyville, Pa.
(Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business Own Home

12. Name... Judson L. Carter

13. Birthplace Pa.

14. Maiden name... Vena Quinby

15. Birthplace Pa.

16. Informant... Ward E. Boote

Address 9412 St. Andrews Way

17. Burial..... Date thereof... Nov. 15, 1947
(Burial, cremation, or removal. Which?) (month) (ddy) (year)

Cemetery or crematory... Cedar Hill Cemetery

Location... Suitland, Md.

18. Funeral director... *Elaine E. Murphy*
Address 8434 Ga. Ave., Silver Spring, Md.19. Nov. 14 1947 *Josephine M. Schaeffer*
(Date rec'd by registrar) Registry Address... 1801 K ST. NW Date signed... Nov. 14, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery

City or town... Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9412 St. Andrews Way

(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1947 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 1947 to Nov. 11 1947

and that I last saw her alive on Nov. 11 1947

Immediate cause of death...

Carcinoma of ovary

DURATION

6 mo.

Due to...

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide..... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

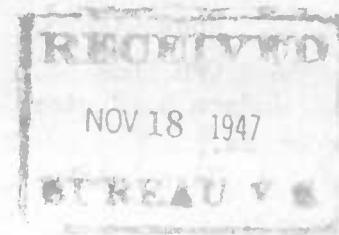
23. SIGNATURE

Louie K. Albert M.D.

M. D. or other

Address... 1801 K ST. NW Date signed... Nov. 14, 1947

Mr. Louis K. Albers
1801 - K. St.
Suite 641.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157e
Reg. Dist. No. 10156 223

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Montgomery

City or town

Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 day : 11 hrs. 3/4

Hospital, institution, or street address where death occurred:

WASHINGTON SANITARIUM & HOSPITAL

How long in hospital or institution?

1 day : 11 3/4 hrs.

3. (a) FULL NAME

Baby girl BOWER, Annael Gertrude

3. (b) Social Security Number

4. Sex

Female

5. Color of race

White

6.(a) Single, married, widowed, or divorced

—

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age..... years

Nov. 20, 1947

8. AGE:

Years

Months

Days

If less than one day

36

hrs.

9. Birthplace

Takoma Park, Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name RALPH EDMUND BOWER

13. Birthplace

PHILADELPHIA, PA.

MOTHER FATHER

14. Maiden name MARION BROTHWELL

15. Birthplace

NEW YORK CITY

16. Informant

WASHINGTON SANITARIUM-Hosp. Records

Address

Takoma Park, Maryland

17. Cremation

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

Date

1947

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

MARYLAND

County

Montgomery

City or town

Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.

9305

Long Branch Pkwy.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

NOVEMBER 21 1947 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

NOV. 20 1947 to NOV. 21 1947

and that I last saw her alive on NOV. 21 1947

Immediate cause of death

Anoxia

DURATION

36 hrs.

Due to Anomalous fusion of pulmonary artery + aorta

Embryonic

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Anomalous fusion of pulm. art. + aorta

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

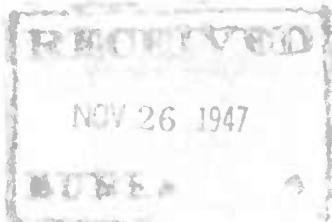
23. SIGNATURE

M. D. or other

Address

Date signed

Silver Spring, Md. 11/21/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10157

CERTIFICATE OF DEATH

160c
Reg. Dist. No. 217

1. PLACE OF DEATH:

County MontgomeryCity or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

The Montgomery County General Hospital, Inc.

How long in hospital or institution?

15 hours

3. (a) FULL NAME

George Frederick Bowie

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

Single.

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

November 9, 1947

8. AGE:

Years

Months

Days

If less than one day

15 hrs. 5 min.

9. Birthplace

Olney, Montgomery County, Md.
(Town, county, and state)

10. Usual occupation

Layman

11. Industry or business

12. Name Frederick Douglas Johnson13. Birthplace Maryland14. Maiden name Alice Virginia Bowie15. Birthplace Olney, Maryland16. Informant Hospital records

Address

17. Burial

(Burial, cremation, or removal, which?)

Date thereof Nov 10-1947
(month) (day) (year)Cemetery or crematory Mt. ZionLocation Montgomery County18. Funeral director Roy W. BarkerAddress Towsonville, Md.19. Nov 10 1947
(Date rec'd by registrar)Gertrude B. Lander
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty MontgomeryCity or town Olney

(If outside city or town limits, write RURAL and give nearest town)

Street No. .

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1947 at 5:56 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 9, 1947 1947, to November 9 1947,and that I last saw h. i.m. alive on November 9 1947.

Immediate cause of death

Atelectasis

DURATION

18 hrs

Due to

Obstruction later

08 hrs

Due to

—

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

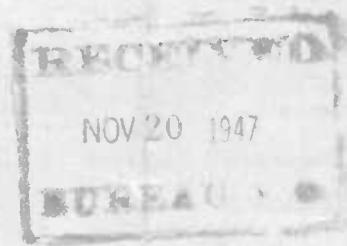
Means of injury

Injured at work

23. SIGNATURE JMB/1

M. D. or other

Address Sandy Spring, Md. Date signed 11/10/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10158

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County..... Montgomery
City or town..... Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 1 month, 2 days
Hospital, institution, or street address where death occurred:..... US Naval Hospital, Bethesda, Md.
How long in hospital or institution?..... 1 month, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Virginia County..... Crockett
City or town..... (If outside city or town limits, write RURAL and give nearest town)
Street No..... Route #1
(If rural, give LOCATION)

3. (a) FULL NAME
BRALLEY, Thomas Oakland

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo. day. yr.)..... February 7, 1925

8. AGE: Years	Months	Days	If less than one day
22	4	6	hrs. min.

9. Birthplace..... Virginia
(Town, county, and state)

10. Usual occupation..... Marine Corps

11. Industry or business

12. Name..... Bralley, Grover dec.

13. Birthplace..... Va.

14. Maiden name..... HURT, Edith dec.

15. Birthplace..... Va.

16. Informant..... sister: Mrs. Helen Haga

Address..... Crockett, Virginia, Rt. #1

17. removal..... Date thereof..... 11-13-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director..... W. W. CHAMBERS W. J. T.

Address..... 1400 Chapin St., N. W., Wash., D.C.

19. 11-13 1947 Mary C. Patterson
(Date rec'd by registrar) Mary C. Patterson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 13 November 1947 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 11 1947 to 13 Nov 1947

and that I last saw h. i.m. alive on 13 November 1947

Immediate cause of death..... Cerebral metastasis.
adenocarcinoma.
carcinomatosis.

Due to.....

Due to..... Adeno Carcinoma of Colon

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations..... Carcinomatosis.
abdominal Date of op. 10/30/47

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

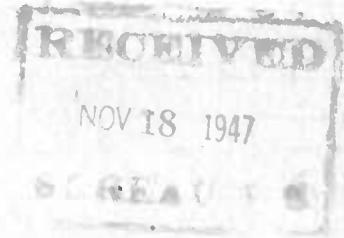
Where did Injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... J. A. MURPHY, Cdr. MOUSN
M. or other

Address..... USNH Bethesda, Md. Date signed 11-13-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10159
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County MONTGOMERY

City or town ROCKVILLE

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Chestnut Lodge SANITARIUM

27 days

Stay in hospital or Inst. (yrs., or mos., or days)

27 days

Stay in this community (yrs., or mos., or days)

27 days

3. (a) FULL NAME

HARRY E. BRANDT

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

MARRIED

6(b) Name of husband or wife

MARY E. BRANDT

7. Birth date of deceased (mo., day, yr.)

May 25, 1863

6(c) If alive, give age

68 years

8. AGE: Years

84

Months

5

Days

10

If less than one day

hrs. min.

9. Birthplace

MECHANICSBURG, PENNA.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FURNITURE MANUFACTURE

MOTHER FATHER

Edward S. BRANDT

13. Birthplace

Penns.

14. Maiden name

Anne Lee Garland

15. Birthplace

Mechanicsburg, Pa

16. Informant

MARY E. BRANDT

Address

629 OAK HILL, HAGERSTOWN, MD.

Burial

(Burial, cremation, or removal. Which?)

Date thereof 11/7/47
(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown Md

18. Funeral director

A. K. Coffman

Address

Hagerstown Md

19. (Date rec'd by registrar)

11-4 1947

E.P. Thompson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County

City or town HAGERS TOWN

Wash

Ward No.

Street No. 629 OAK HILL

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

NOV. 4, 1947, at 1:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 8, 1947, to Nov. 4, 1947,

and that I last saw him alive on Nov. 4, 1947.

Immediate cause of death

ACUTE HEART FAILURE

DURATION

3 hrs.

Due to HYPERTENSIVE CARDIO-
VASCULAR DISEASE

25 yrs.

Due to

Other conditions Enlarged Prostate

Bilateral Deafness

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Joseph W. Cox, M.D.

M. D. or other

Address Chestnut Lodge Sanitarium

Date signed 11/7/47

Rockville, Md.

RECEIVED

NOV 5 1947

BUREAU P.D.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

928

10160

216

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County... Montgomery

City or town... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hours

Hospital, Institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D. C.

County...

Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No... 1807 4th Street, Northwest

(If rural, give LOCATION)

2.(a) If veteran, name war... WW I

3.(a) FULL NAME

BROWN, William Edward

4. Sex

male

5. Color or race

Negro

6.(a) Single, married, widowed, or divorced

unknown

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

11 February 1892

8. AGE:

Years
55Months
8Days
27

If less than one day

hrs. min.

9. Birthplace..... Petersville, Maryland
(Town, county, and state)

10. Usual occupation..... Chauffeur

11. Industry or business

MOTHER FATHER
12. Name..... unknown

13. Birthplace..... unknown

14. Maiden name..... unknown

15. Birthplace..... unknown

16. Informant..... Friend: Mr. John Brown

Address 1807 4th St., NW, Washington, D. C.

17. burial..... Date thereof..... 11-13-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington National Cemetery

Location..... Arlington, Virginia

18. Funeral director..... Frazier Funeral Home
Address 389 Rhode Island Ave., NW Wash., D.C.19. 11-10 1947
(Date rec'd by registrar) Mary C. Patterson
Mary C. Patterson
Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 8 November 1947 at 5:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11-8-1947 to 11-8-1947

and that I last saw him alive on 11-8-1947

Immediate cause of death.....

Rheumatic Heart Disease
with congestive failure

DURATION

?

Due to.....

Due to.....

Other conditions..... Aortic and mitral stenosis

?

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE..... L. E. WATTERS, LTJC MC USNR
M. D. or other

Address..... USNH, Bethesda, Md. Date signed..... 11-10-47

RECEIVED

NOV 14 1947

LIBRARY

PLEASE WRITE PLAINLY, WITH UNLEADING INK. Supply every item of information carefully. In correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10161

93d

Reg. Dist. No. 223

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Montgomery

City or town

Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Two years

Hospital, Institution, or street address where death occurred:

345 Boyd Avenue

How long in hospital or institution?

3. (a) FULL NAME

George Isler Bush

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

Mrs. Bessie

Elizabeth Bush

6. (c) If alive, give age 64 year

7. Birth date of deceased (mo., day, yr.)

April 3, 1882

8. AGE:

Years
65Months
7Days
27If less than one day
hrs. min.

9. Birthplace

19 Reading Pa.

(Town, county, and state)

10. Usual occupation

Mechanic

11. Industry or business

William Bush

MOTHER FATHER

12. Name

19 Reading, Pa.

13. Birthplace

Hope Eppenheimer

14. Maiden name

19 Reading, Pa.

15. Birthplace

Mr. Joseph Smith

16. Informant

Address 9210 Midwood Rd., Silver Spring, Md.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof Dec 21, 1947

(month) (day) (year)

Cemetery or crematory

Banc Episcopal Church Cemetery

Location

Woodside, Silver Spring, Md.

18. Funeral director

Arthur Ballou

Address 254 Carroll St. N. Takoma Park, D.C.

19. File no.

1847

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 345 Boyd Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 1947, at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18, 1947, to Nov. 29, 1947,

and that I last saw him alive on November 29, 1947.

Immediate cause of death

Coronary Occlusion

Due to Arteriosclerotic heart disease with recurring 5 yrs. ?
attacks of Angina Pectoris

Other conditions

12 softness

20 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wallace H. Monk M.D.

805 Carroll Avenue, M. D. or other

Takoma Park, Md. Date signed 11-30-47

RECEIVED

DEC 4 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160c

10162

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 day

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?..... 1 day

3. (a) FULL NAME

CARROLL, Baby Boy

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

W-US

single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Nov. 24, 1947

8. AGE: Years

Months

Days

If less than one day

2 hrs. 20 min.

9. Birthplace..... Md.

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

12. Name..... CARROLL, Richard

13. Birthplace

14. Maiden name..... HAAS, Ann Carolyn

15. Birthplace..... N.C.

16. Informant..... Mother: Mrs. Ann C. Carroll

Address..... 556 14th St., S.E., Wash., D.C.

17. turned over to:..... Date thereof..... 11-25-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Location..... Pathological Dept.

Location..... Naval Medical School, Bethesda, Md.

18. Location..... US Naval Medical School,

Address..... National Naval Medical Center, Bethesda, Md.

19. 11-25-47
(Date rec'd by registrar) Mary C. Patterson
Mary C. Patterson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C.

County.....

Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 556 14th St., S.E.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov. 24 1947 at 3:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 24 1947 to Nov. 24 1947 and that I last saw h. im. alive on Nov. 24 1947

Immediate cause of death.....

Prematurity, immaturity
5 1/2 month Gestation

Due to..... Placenta praevia -

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... PAUL PETERSON, Capt. MC USN
M. D. or other

Address..... USNH Bethesda, Md.

Date signed..... 11-25-47

RECORDED

NOV 29 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10163

216

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		Montgomery
County	Bethesda (rural)	
(If outside city or town limits, write RURAL and give nearest town)		
How long in above place of death? 5 years, 1 mo., 9 days		
Hospital, institution, or street address where death occurred: U. S. NAVAL HOSPITAL, Bethesda, Md.		
How long in hospital or institution? 5 yrs., 1 mon., 9 days		

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State	County
Washington, D. C.	
(If outside city or town limits, write RURAL and give nearest town)	
Street No. 2126 Conn. Avenue, N.W.	
(If rural, give LOCATION) WWI	

2.(a) If veteran, name war

3. (a) FULL NAME
CLARK, Frank Hodges, Rear Admiral USN Ret. Inact.

3. (b) Social Security Number

4. Sex	B. Color or race	C. (a) Single, married, widowed, or divorced
Male	W-US	married
B. (b) Name of husband or wife Mrs. Nina Clark		
5. Birth date of deceased (mo., day, yr.) December 18, 1871		C. (c) If alive, give age years

6. AGE: Years	Months	Days	If less than one day		
75	10	18	hrs.	min.	

7. Birthplace Mass.
(Town, county, and state)

8. Usual occupation Retired Navy

9. Industry or business

MOTHER DAUGHTER
10. Name CLARK, Frank H. dec.
11. Birthplace Mass.

12. Maiden name PHILBRICK, Mary dec.
13. Birthplace Mass.

14. Informant Mrs. Nina Clark
Address 2126 Conn. Avenue, N.W., Wash., D.C.

15. Burial Date thereof 11-10-47
(Burial, cremation, or removal; When?) (month) (day) (year)
Cemetery or crematory Arlington National

Location Arlington, Va. *J. E. Garrett*
16. Funeral director Joseph Gawler *Joseph Gawler*
Address 1750 Penn., Avenue, N.W., Wash., D.C.

17. Date registered 11-7-47
18. Name of physician Mary G. Patterson
Address 1750 Penn., Avenue, N.W., Wash., D.C.

19. (Date record by registrar) 11-7-47
Mary G. Patterson

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1947 at 9:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 Sept. 1942 to 6 November 1947 and that I last saw him alive on 6 November 1947.

Immediate cause of death Coronary Thrombosis with myocardial infarction
Due to Atherosclerosis Generalized
Duration 36 hours

Due to Arterial Hypertension
Other conditions Central Hemorrhage
(Include pregnancy within 8 months of death) 6 years
8 years
5 years

Major findings or operations Same as above
Date of op.

Autopsy results Same as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (Country) (State)

Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE *T. E. Garrett*
T. E. GARRETT, Cdr. MC USN
M. B. or other

Address USNH Bethesda, Md. Date signed 11-7-47

RECEIVED

NOV 14 1947

BUREAU V 6



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

10164

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County.....

Montgomery

City or town.....

Seneca

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *12 years*

Hospital, institution, or street address where death occurred:

None

How long in hospital or institution? *None*

3. (a) FULL NAME

Mary Agnes Connell

4. Sex

female

5. Color or race

white

6.(a) Single, married, widowed or divorced

single

6.(b) Name of husband or wife

None

7. Birth date of deceased (mo., day, yr.)

Jan. 21, 1865

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

82

9

28

hrs.

min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation None

11. Industry or business None

12. Name William G. Connell

13. Birthplace Maryland

14. Maiden name Ann Counselman

15. Birthplace Washington, D.C.

16. Informant Sidney Connell

Address Seneca, Maryland.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 21, 1947
(month) (day) (year)

Cemetery or crematory Rockville Union Cemetery

Location Rockville, Maryland

18. Funeral director Wm. Ladd Lumpkin

Address Bethesda, Md.

19. 11/21/

(Date rec'd by registrar)

1947

S P Shampoor

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Montgomery

City or town.....

Seneca

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

None

(If rural, give LOCATION)

2.(a) If veteran, name war

None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19- 1947 at 2 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 27- 1947 to November 19- 1947

and that I last saw her alive on Nov. 18- 1947

Immediate cause of death

Cerebral Hemorrhage

DURATION

20 hrs.

Due to

Due to

Other conditions

Senility Cardio-neuritic

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURES

M. D. or other

Address *Guthersburg, Md.* Date signed *11-20-47*

[RECORDED]

NOV 26 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10165

CERTIFICATE OF DEATH

Reg. Dist. No. 223.

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Washington Sanitarium & Hospital

How long in hospital or institution?..... 10 weeks

3. (a) FULL NAME

MRS. GRACE V. CROTTES

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

female

white

widowed

6.(b) Name of husband or wife

Corbin Central

7. Birth date of deceased (mo., day, yr.)

July 22nd. 1896

6.(c) If alive, give age years

8. AGE:

Years
51Months
4Days
5

If less than one day

hrs.

min.

9. Birthplace

Lexington, N. C.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

Willard Sink

12. Name

Irene McKinley

13. Birthplace

Tennessee

14. Maiden name

Unk North Carolina

15. Birthplace

Irene McKinley

16. Informant

Mr. Cody F. Crotts (son)

Address

1111 Mt. Olivet St. N.E. Wash.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof... 12-1-1947

(month) (day) (year)

Cemetery or crematory

Colesville Methodist Church

Location

Colesville, Montg. Co. Md.

18. Funeral director

Elaine E. Parry

Address

Silver Spring, Md.

19. (Date rec'd by registrar)

Nov. 29 1947

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... Montg.

City or town..... Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1703 Dennis Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war..... no

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

November 29 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

April 8 1943 to Nov. 29 1947

and that I last saw her alive on Nov. 27 1947

Immediate cause of death

Cachexia

DURATION

3 mos.

Due to Generalized carcinomatosis 6 mos.

Due to Primary adenocarcinoma of transverse colon 4 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations Right half of colon resected for adenocarcinoma Date of op March 1945

Autopsy results Generalized carcinomatosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address..... Silver Spring, Md. Date signed 11/27/47

RECORDED

DEC 3 1947

SEARCHED

PLEASE WRITE PLAINLY, WITH UNEADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10166
50

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery County

City or town Chevy Chase, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs.

Hospital, institution, or street address where death occurred:

Cummings Lane,

How long in hospital or institution?

3. (a) FULL NAME

CUMMINGS, Zelpha Lawyer

4. Sex

5. Color or race

Female

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife Andrew J. Cummings

7. Birth date of deceased (mo., day, yr.)

July 28, 1882

6.(c) If alive, give age years

8. AGE: Years

65

Months

3.

Days

5

If less than one day

hrs. min.

9. Birthplace Milroy, Pa.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name John Contener

13. Birthplace Pa.

14. Maiden name ? Ross

15. Birthplace Pa.

16. Informant Andrew J. Cummings, Jr.

Address 6625 Hillendale, Ch. Ch. Md.

17. Burial

Date thereof 11/6/47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory St. Johns Cemetery

Location Forest Glen, Maryland

18. Funeral director Wm Reuben Cumphrey

Address 7557 Wis. Ave. Bethesda, Maryland

19. 11/14/47

(Date rec'd by registrar)

Nm 6 John

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Montgomery

City or town Chevy Chase, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Cummings Lane,

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

214-12-7376

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 3 1947 at 9:32 AM

21. I CERTIFY that he occurred on the date above stated; that I attended deceased from

May 1947 to Nov. 3 1947

and that I last saw him alive on Nov. 3 1947

Immediate cause of death

Glen. Carcinoma of the
breast lungs. Geng glands

DURATION

2 yrs

Due to

Due to

Other conditions Acute respiratory 8 hrs.
& cardiac failure

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 3511-16 N.W. Date signed 11/3/47

RECEIVED

NOV 10 1947

BUREAU F.B.I.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

10167
10167

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... Montgomery

City or town... Takoma Park, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

71 days 14 hours 45 min

Hospital, Institution, or street address where death occurred:

Washington Sanitarium & Hospital

How long in hospital or institution? 71 days 14 hours 45 min

3. (a) FULL NAME

Mr. James J. Davis

4. Sex

Male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Jeanette R. Davis

7. Birth date of deceased (mo., day, yr.)

October 27 1873

6. (c) If alive, give age years

8. AGE:

74

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

South Wales

(Town, county, and state)

10. Usual occupation

Fraternity Organizer

11. Industry or business

U.S. Govt.

MOTHER FATHER

David J. Davis

12. Name

David J. Davis

13. Birthplace

South Wales

14. Maiden name

Esther Ford Nichols

15. Birthplace

South Wales

16. Informant

Self

Address

Removal

(Burial, cremation, or removal. Which?)

Date thereof November 23 1947
(month) (day) (year)

Cemetery or crematory

Location Pittsburgh, Pennsylvania

The A.W. Jones Co.

18. Funeral director

Address 2901-14th Street N.W. Washington D.C.

19. Mrs. 72

(Date rec'd by registrar)

19 47 Josephine Schaeffer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D. C.

County

City or town... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9618 Prospect St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war... None

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 22 1947 at 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 11 1947 to Nov. 22 1947

and that I last saw him alive on Nov. 21 1947

Immediate cause of death

Congestive Cardiac Failure

Due to Hypertension

Due to Arteriosclerosis

Other conditions Chronic Nephritis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

X

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

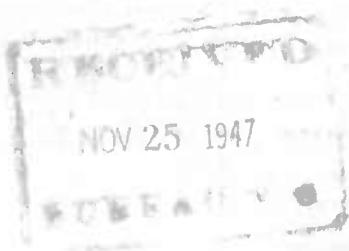
Injured at work?

23. SIGNATURE

Robert G. Davis M.D.

Address Takoma Park Md

Date signed 11/22/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

108
10168

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County MarylandCity or town Bethesda Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 11-21-47 - 10:45 A.M.Hospital, Institution, or street address where death occurred: Suburban Hosp8600 Old Georgetown Rd - Bethesda MDHow long in hospital or institution? Since 11-21-47 10:45 A.M.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WashingtonCounty D. C.City or town Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2525 Pennsylvania Ave. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3. (a) FULL NAME

Mr Stanley Deasy

4. Sex

5. Color or race

6. (a) Single, married, widowed, divorced

m.

W

Single

6. (b) Name of husband or wife None

7. Birth date of deceased (mo. day, yr.)

January 15, 1896

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

51

10

7

hrs.

min.

9. Birthplace Cincinnati, Ohio

(Town, county, and state)

10. Usual occupation Manager

11. Industry or business

Restaurant Business

MOTHER FATHER

12. Name Timothy Deasy13. Birthplace Cincinnati, Ohio14. Maiden name Ann McHugh

15. Birthplace

Kentucky16. Informant Mrs. Florence AldemeyerAddress Cincinnati 2, Ohio17. Removal-Transit Date thereof Nov. 23, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fuldrer Funeral HomeLocation Cincinnati, Ohio18. Funeral director W.M. Fuldner-PumpkinayAddress Bethesda 14, Maryland19. 11/23/47 (Date rec'd by Registrar)Mr E John
Registrar

3. (b) Social Security Number

yes but unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22-47

19

al

30

A

21. I CERTIFY that death occurred on the date above stated; That I attended deceased from

Nov. 19

19 47, 10

Nov 22

19 47

and that I last saw him alive on Nov 21 19 47

Immediate cause of death

Lobar Pneumonia

DURATION

1 wk.

Due to

Due to

Other conditions Rheumatic Heart Disease 30 yrs

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results Lobar Pneumonia, Rheumatic Heart Disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

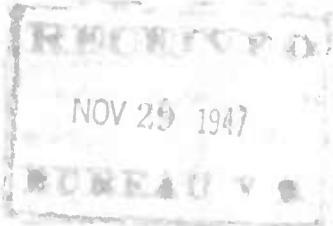
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

J. Robert Heekin Jr. M.D.
M. D. or other
Address 144-B Rhode Island Ave NW
Date signed 11/23/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1310

10169

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Nearest town or street address where death occurred:

619 Gist Ave..

How long in hospital or institution?

3. (a) FULL NAME

MRS. BELLE GOULDING DICKEY

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

female

white

widowed

6.(b) Name of husband or wife Charles A.

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.) Feb. 5th. 1869

8. AGE: Years Months Days If less than one day
78 9 19 hrs. min.

9. Birthplace Minnesota

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name John W. Goulding

13. Birthplace Minn.

14. Maiden name Abigail Rines

15. Birthplace Minn.

16. Informant Mrs. Dorothy D. Boss

Address 619 Gist Ave. Silver Spring.

17. Removal & Burial Date thereof 11/26/1947
(Burial, cremation, or removal. Which?)

Oak Knolls

Cemetery or crematory Princeton, Middle Licks Co. Minn

18. Funeral director Barbara Lumphey

Address 8434 Ga. Ave. Silver Spring, Md.

19. Nov. 25 1947 Josephine M. Schaeffer
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 619 Gist Ave..

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 24

1947 at 2²⁵ a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10-4

1947 to 11-24 1947

and that I last saw her alive on 11-21 1947

Immediate cause of death

Cardiac Failure

DURATION

Due to Hypertension

Due to Chronic Nephritis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Kleen & Harding MD
M. D. or other
Address 113 Carroll St NW
Date signed 11-24-47
Wash DC



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10170

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

Montgomery

County

Silver Spring

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1704 NOYES LANE

How long in hospital or institution?

3. (a) FULL NAME

Babette Dickinson

4. Sex

FEMALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

WIDOWED

6.(b) Name of husband or wife

FREDERICK M.

7. Birth date of deceased (mo. day, yr.)

FEB - 4TH 1878

6.(c) If alive, give age years

8. AGE:

Years	Months	Days	If less than one day
69	9	10	hrs. min.

9. Birthplace

GERMANY

(Town, county, and state)

10. Usual occupation

HOUSEWIFE

11. Industry or business

12. Name

JOHN WIRTH

13. Birthplace

GERMANY

14. Maiden name

UNKNOWN

15. Birthplace

UNKNOWN

16. Informant

MR HARRY J. DICKINSON (son)

Address 8814 - 1st AVE SILVER SPRING MD

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof Nov 17 1947

(month) (day) (year)

Cemetery or crematory FORT LINCOLN CEMETERY

Location BLADENSBURG RD PRINCE GEORGES CO MD

18. Funeral director

Wm and E. Campbell

Address SILVER SPRING MD

19. Nov. 17 1947
(Date rec'd by registrar)

Register

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County MONTGOMERY

City or town SILVER SPRING

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1704 NOYES LANE

(If rural, give LOCATION)

2.(a) If veteran, name war

No

3. (b) Social Security Number

NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1947 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Def med Etan care to 19.

and that I last saw h. alive on 19.

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

Frank J. Banchart M.D.

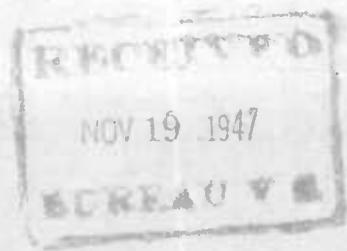
Died med Etan

M. D. or other

Address

Maithasbury M.D.

Date signed Nov 14 1947



PLEASE WRITE PLAINLY, WITH ONE LEADING INK. Supply every item of information carefully. If age is especially important, physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10171

170C

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Suburban Hospital
3 hours

How long in hospital or institution?

3. (a) FULL NAME

William Calvin Dodson

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo. day yr.)

Jan. 19, 1923

8. AGE:

Years
24Months
9Days
15If less than one day
hrs. . min. .

9. Birthplace

Silver Spring, Mont. Md.
(Town, county, and state)

10. Usual occupation

Plumber

11. Industry or business

12. Name Hezekiah Dodson13. Birthplace Culpepper, Va.14. Maiden name Flossie Watkins15. Birthplace Brownsville, Md.16. Informant Gordon J. Dodson

Address

17. Burial Date thereof Nov. 6, 1947
(Burial, cremation, or removal. Which?)

Cemetery or crematory Arlington National Cemetery
 Location Arlington, Va.

18. Funeral director

J. Leslie Stalers
 Address 254 Carroll St. N.W., Thomas Park Bldg., D.C.

19. 11/3 1947
(Date rec'd by registrar)Mm E. Jones

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

MontgomeryCity or town FAIRLAND (R.F.D. 2, SILVER SPRING)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

WORLD WAR II

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 3

1947, 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sympathetic care

1947, to 1947.

and that I last saw him alive on 1947.

Immediate cause of death

Fracture of skull

Due to

Auto accident (accidental)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accidentDate of 11-3-47Where did injury occur? home

Montgomery

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

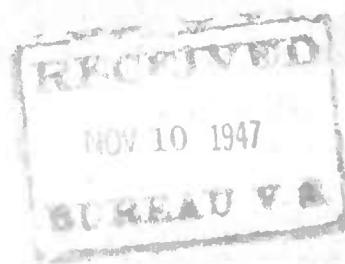
Montgomery

Means of injury auto accident Injured at work? noFrank J. Broeschke M.D.Frank J. Broeschke

M. D. or other

23. SIGNATURE

Frank J. BroeschkeAddress MontgomeryDate signed 11-3-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

101102

Reg. Dist. No.

1. PLACE OF DEATH:

County... Montgomery

City or town... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

10 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?

10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Va. County....

City or town... Millboro Springs

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

WWII

2.(a) If veteran, name war.....

3. (a) FULL NAME

DRISCOLL, Marion Raymond

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

W-US

single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

July 2, 1898

8. AGE:

Years
49Months
4Days
14

It less than one day

hra. min.

9. Birthplace.....

Va.

(Town, county, and state)

10. Usual occupation.....

unknown

11. Industry or business

12. Name DRISCOLL, James dec.

13. Birthplace Va.

14. Maiden name GILLOCK, Bessie dec.

15. Birthplace Va.

16. Informant sister: Mrs. W. B. Wood

Address Millboro Springs, Va.

17. burial Date thereof 11-18-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Clifton Forge Cemetery

Location Clifton Forge, Va.

18. Funeral director William Reuben Pumphrey J.P.

Address 7557 Wis.Ave., Bethesda, Md.

19. 11-16- 1947

Mary C. Patterson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 November 1947 at 2:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 November 1947 to 16 November 1947 and that I last saw h. im alive on 16 November 1947.

Immediate cause of death Coronary
disections

Due to Coronary sclerosis

Due to Esophageal intussusception -

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

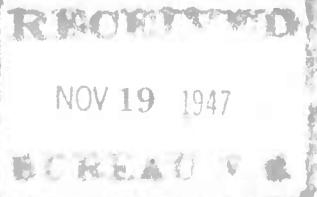
P. E. Billman - Injured at work?

D. E. BILLMAN, Lt JC MC USN

23. SIGNATURE.....

USNH Bethesda, Md.

M. D. or other 11-16-47
Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46e

10173

716

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
County..... Montgomery
City or town..... Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months

Hospital, institution, or street address where death occurred:
Wilson Lane

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County..... Montgomery

City or town..... Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. Wilson Lane
(If rural, give LOCATION)

2.(a) If veteran, name war..... None

3. (b) Social Security Number
None

3. (a) FULL NAME
Dr. William S. Dysinger

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced		
Male	White	Married		
6.(b) Name of husband or wife..... Laura M. Dysinger				
7. Birth date of deceased (mo., day, yr.)		6.(c) If alive, give age..... 79 years		
October 1st, 1862				
8. AGE:	Years	Months	Days	If less than one day
85	85	1	12	- hrs. - min.

9. Birthplace..... Mifflintown, Pa.
(Town, county, and state)

10. Usual occupation..... Minister (Retired)

11. Industry or business..... Luthern Church

12. Name..... Jacob Dysinger

13. Birthplace..... Penn.

14. Maiden name..... Mary Patterson

15. Birthplace..... Penn.

16. Informant..... Mrs. Laura M. Dysinger (wife)

Address..... Wilson La., Bethesda, Maryland

17. Burial..... Nov. 15, 1947
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... Rockville Union Cemetery

Location..... Rockville, Maryland

18. Funeral director..... W. Keeble Humphrey

Address..... Bethesda, Maryland

19. 11/15/47 1947 2pm E. lobes
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 13th, 1947 at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from FEBRUARY 1947 to NOVEMBER 12 1947

and that I last saw him alive on NOVEMBER 12 1947

Immediate cause of death..... ACUTERESPIRATORY FAILURE DURATION

Due to..... CARCINOMA OF THE DESCENDING COLON WITH EXTENSIVE METASTASES ONE YEAR

Due to.....

Other conditions..... ANEMIA, SEMI HYPER TENSION

WITH CEREBRAL ARTERIOSCLEROSIS

(Include pregnancy within 3 months of death)

Major findings or operations..... COLOSTOMY PERFORMED AUG. 1947

LAB REPORT: ADENOCARCINOMA Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

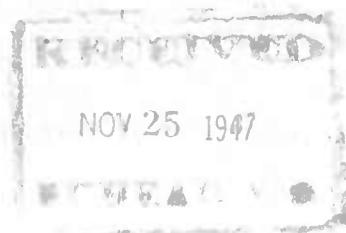
Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other.....

Address..... 180 Eye St., N.W. Wash.D.C. Date signed..... 15.11.47



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

193

10174

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Sudden death.

Hospital, institution, or street address where death occurred:

Cedar Pkwy. and Oliver St.

How long in hospital or institution? --

3. (a) FULL NAME

Malone Sibley Eddleman

4. Sex

Male white single

6.(b) Name of husband or wife: ---

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1912

8. AGE: Years Months Days If less than one day
35 1 28 hrs. min.9. Birthplace Memphis, Tenn.
(Town, county, and state)

10. Usual occupation Crane Mechanic

11. Industry or business Bles Construction Co.

12. Name Wallace R. Eddleman

13. Birthplace Georgia

14. Maiden name Myrtle Vincent

15. Birthplace Indiana

16. Informant Wallace R. Eddleman

Address 9505 Baltimore Blvd., Berwyn, Md.

17. Burial transit Date thereof Nov. 8, 1947
(Burial or removal. When?) (month) (day) (year)

Cemetery or crematory Memphis, Tenn.

Location Memphis, Tenn.

18. Funeral director Wm. L. Eddleman Peemphrey

Address Bethesda, Maryland.

19. 11/7 1947 2pm 6 Janes
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Berwyn
(If outside city or town limits, write RURAL and give nearest town)Street No. 9505 Baltimore Blvd.
(If rural, give LOCATION)

2.(a) If veteran, name war World War II; 347-11111

3. (b) Social Security Number

Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7, 1947 19 7:30A.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19. to 19. and that I last saw h. alive on

Immediate cause of death DEP. MED. EXAM. CASE

DURATION Died Suddenly

Due to Electrocution
Accidental

Due to

Other conditions
(Include pregnancy within 3 months of death)Major findings of operations
Date of op.Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Nov. 7, 1947

Where did injury occur? Bethesda Montgomery Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Place

Means of injury Electrocution Injured at work? Yes

Signature Frank J. Broschart

23. SIGNATURE Frank J. Broschart, M.D.
Deputy Medical Examiner or other

Address Gaithersburg, Md. Date signed Nov. 7, 1947

RECEIVED

NOV 11 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10175

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH

County

City or town

Gaithersburg, Montgomery

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Twenty years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

MABLE, LLOYD, ELDER

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

FEMALE

WHITE

WIDOWED

6.(b) Name of husband or wife

JAMES LEO, ELDER

7. Birth date of deceased (mo., day, yr.)

SEPT. 29. 1895

6.(c) If alive, give age years

8. AGE: Years

Months

Days

If less than one day

52

1

26

hrs.

min.

9. Birthplace

MARYLAND

(Town, county, and state)

10. Usual occupation

FARMING

11. Industry or business

FARM

MOTHER

FATHER

12. Name

OLIVER BRIGGS

13. Birthplace

MARYLAND

14. Maiden name

ELLA PENN BRIGGS

15. Birthplace

MARYLAND

16. Informant

ELLA E HAWKINS

Address

GAITHERSBURG MD.

17. BURIAL

Date thereof NOV 27, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory ST MARYS

Location

ROCKVILLE

18. Funeral director

ROY W BARBER

Address

LAYTONSVILLE

19. LI-24

1947

(Date rec'd by registrar)

J. P. Thompson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY

City or town SHADY GROVE ROAD

Street No. GAITHERSBURG

(If rural, give LOCATION) NONE

3. (b) Social Security Number

NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1947 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1940 19... to Nov 24 1947

and that I last saw him alive on Nov 24 1947

Immediate cause of death

Cerebral arterioclerosis & hypertension 5 years

DURATION

Due to

Due to

Cerebral hemorrhage
Right hemiplegia

11 months

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

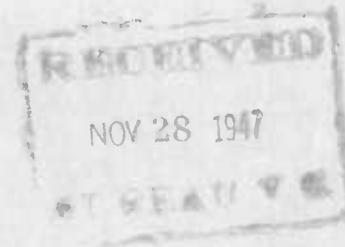
Means of injury

Injured at work?

23. SIGNATURE J. P. Thompson, M.D.

M. D. or other

Address Rockville, Md. Date signed Nov 24, 1947



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10176
218

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County.....

City or town.....

Montgomery Co.
Gaithersburg Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 3 mo -

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Robert M. Fairbanks

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Aug 8 1847

8. AGE:

Years

Months

Days

It less than one day

3

4

hrs.

min.

9. Birthplace.....

Montgomery Co. Md.

(Town, county, and state)

10. Usual occupation.....

Dr

11. Industry or business.....

Labourer

MOTHER FATHER

12. Name.....

Elizabeth Fairbanks

MOTHER FATHER

13. Birthplace.....

Montgomery Co. Md.

14. Maiden name.....

Margaret Stone Social League

15. Birthplace.....

Montgomery Co. Rockville Md.

16. Informant.....

Margaret Stone Social League

Address.....

Montgomery Co. Rockville Md.

17. Burial

Burial

Date thereof..... 11/12/49

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

Forest Oak Cemetery

Location.....

Gaithersburg Md.

18. Funeral director.....

Lemuel C. Gaither

Address.....

Gaithersburg Md.

19. No. - 12 Date rec'd by registrar) 1947

Abner G. Cooke

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md

County.....

Montgomery

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Nov 11

1947 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Died med. Exam care

19 to 19

and that I last saw h..... alive on

19

Immediate cause of death.....

Congenital heart disease

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Copy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of Injury.....

Injured at work?

23. SIGNATURE.....

Frank J. Broschart M.D.
Died med. Exam

M. D. or other

Address.....

Gaithersburg Md. Date signed 11-11-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50*

10177

CERTIFICATE OF DEATH

Reg. Dist. No. 246

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Suburban Hospital 8600 George Town Rd
old Bethesda MD

How long in hospital or institution?

8 days

3. (a) FULL NAME

Mrs. Minta Foster

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

+ White w. d.

6. (b) Name of husband or wife

Orrin Foster Deceased

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

April 27, 1879

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Council Bluff, Iowa

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name William J. Bamer

13. Birthplace

Kentucky

14. Maiden name

Mary Roberts

15. Birthplace

Missouri

16. Informant

Hosp records

Address

17. Burial
(Burial, cremation, or removal. Which?)Date thereof 11/15/47
(month) (day) (year)

Cemetery or crematory

Arlington Nat Cem

Location

" Va

18. Funeral director

J. H. Hines Co.

Address

2901 14th NW19. 11/3/471947Mr. E. Jones

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State 44 47 - Que St. N.W. CountyCity or town Washington, D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1947 at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1945 to Nov 3 1947and that I last saw her alive on NOV 2 1947

Immediate cause of death

Generalized carcinomatosisDue to Primary Breast Carcinoma

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

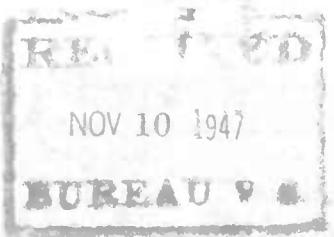
Means of injury

Injured at work?

23. SIGNATURE P.P. Anderson M.D.

M. D. or other

Address Washington, D.C. Date signed 11-3-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

10178
213

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... *Montgomery*
City or town... *Rockville*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

37 years

Hospital, institution, or street address where death occurred:

415 - West Mount Avn

How long in hospital or institution?

3. (a) FULL NAME

Louis A. Gardiner

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

Mary A. Gardiner

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age *77* years*February 25 - 1860*

8. AGE:

Years *87* Months *8* Days *27* If less than one day

9. Birthplace

Town, county, and state) *Montgomery County Maryland*

10. Usual occupation

Farm - Farmer

11. Industry or business

William A. Gardiner

12. Name

Maryland

13. Birthplace

Mary Bowles

14. Maiden name

Mary Bowles

15. Birthplace

Maryland

16. Informant

Georgia L. Gardiner

Address

Charlesville - Maryland

17. Burial

Date thereof *Nov. 24/47*
(Burial, cremation, or removal. Which?)
(month day year)

Cemetery or crematory

St. Mary's Catholic Ch -

Location

Barnstable - Montgomery Co - Md

18. Funeral director

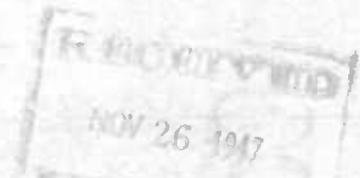
Wm. Brink Thompson

Address

*Rockville - Maryland*19. *11/23*

(Date rec'd by registrar)

19. *47*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10179

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

Montgomery

County

Rockville 100 Forest Avenue

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

100 Forest Avenue

How long in hospital or institution? No stay

3. (a) FULL NAME

ADA BOYD GLASSIE

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

None

7. Birth date of deceased (mo. day. yr.)

September 29, 1874

6.(c) If alive, give age years

8. AGE:

Years	Months	Days	If less than one day
73	1	15	hrs. min.

9. Birthplace

Washington, D. C.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

None

MOTHER FATHER

12. Name Daniel W. Glassie

13. Birthplace Buffalo, N. Y.

Minna Nash

14. Maiden name

15. Birthplace Nashville, Tenn.

16. Informant Henry H. Glassie, Jr.

Address 6521 Brookville Rd., Chevy Chase

17. Burial

Date thereof Nov. 18, 1947
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington, Virginia

18. Funeral director Wm. L. L. Humphrey

Address Rockville, Maryland

November 18, 1947

(Date rec'd by registrar)

E.P. Thompson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

State

Montgomery

County

Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

100 Forest Avenue

(If rural, give LOCATION)

No.

2.(a) If veteran, name war

3. (b) Social Security Number

NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1947, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1947 to Nov. 14, 1947,
and that I last saw her alive on Nov. 1, 1947.

Immediate cause of death

Probably coronary occlusion

DURATION

Five minutes

Due to

{ Arteriosclerosis, hypertension with cardiac } 5 years

{ Myocarditis with cardiac }

Other conditions

{ Hypertrophy, Choroiditis, blind }

{ Past history of deafness }

? 10 years

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

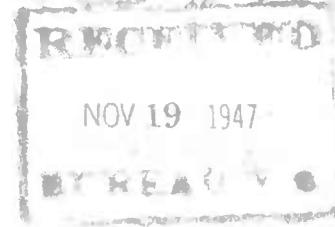
23. SIGNATURE

J. G. Lathem, M.D.

M. D. or other

Address

Rockville, Md. Date signed 11/15/47



~~RECORDED~~
RECORDED

NOV 17 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

10181

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Takoma Park, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 3 yrs.

Household institution, or street address where death occurred

116 Park Ave.

How long in hospital or institution?

3. (a) FULL NAME

Walter Gilbert

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

Cora May Gregg

7. Birth date of deceased (mo. day, yr.)

6. (c) If alive, give age

years

July 4 1879

8. AGE:

Years Months Days If less than one day

80 7 4 25 hrs. min.

9. Birthplace

Leesburg Va.

(Town, county, and state)

10. Usual occupation

Full of Agriculture

11. Industry or business

Park Admin. U.S. Gov.

MOTHER

FATHER

Eliezer Gregg

12. Name

Loydston County Va.

13. Birthplace

Katherine Stevens

14. Maiden name

Loydston County Va

15. Birthplace

Mrs. Frank K. Appert

16. Informant

303 Ethan Allen Ave Takoma Park

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof DEC - 7 - 1947
(month) (day) (year)

Cemetery or crematory ROCK CREEK

Location WASHINGTON D.C.

Funeral director Warner & Sons

Address SILVER SPRING

Dec 1 1947

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County Montgomery

City or town

116 Park Ave. (If outside city or town limits, write RURAL and give nearest town)

Street No.

Takoma Park Md. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 29 1947 at 8:30 AM

May 5 1947 to Nov 29 1947

and that I last saw him alive on Nov 29 1947

Immediate cause of death

Cerebral hemorrhage. DURATION

11/27/47

Due to Hypertension

Due to cerebral arteriosclerosis

3 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur City or town County State

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Howard J. Moore M.D. or other

Address Carroll Ave Takoma Park Date signed 11/29/47

RECEIVED

DEC 4 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10182

CERTIFICATE OF DEATH

131a
Reg. Dist. No. 217

1. PLACE OF DEATH:

County.....

Montgomery

City or town.....

Olney Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

6 hours

Hospital, institution, or street address where death occurred:

Montgomery County General Hospital

How long in hospital or institution?.....

6 hours

3. (a) FULL NAME

Miss BERTHA HANSHEW

4. Sex

F

5. Color or race

white

6. (c) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

JULY 14, 1885

8. (c) If alive, give age..... years

8. AGE:

Years
62Months
3Days
22

If less than one day

hrs.
min.

9. Birthplace.....

Frederick, Md.

(Town, county, and state)

10. Usual occupation.....

Domestic worker

11. Industry or business

FATHER

12. Name..... Mr HENRY HANSHEW

MOTHER

13. Birthplace..... Frederick Maryland

MOTHER

14. Maiden name..... Mary Mariant

FATHER

15. Birthplace..... Chambidge Virginia

FATHER

16. Informant..... Mrs William C. Ferguson

MOTHER

Address..... Pleasant 8641/2901 Wheaton Rd, Kensington Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... NOV. 8-12
(month) (day) (year)

Cemetery or crematory.....

Mt Olivet Cemetery

FATHER

Location..... Frederick, Md.

MOTHER

Wm Reuben Humphrey

18. Funeral director.....

BETHESDA

M.D.

BETHESDA

Md.

BETHESDA



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

468 A

10183

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH:

County *Baltimore County*City or town *Takoma Park*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *14*Hospital, institution, or street address where death occurred: *Washington Son. & Hospital*How long in hospital or institution? *14 days*

3. (a) FULL NAME

*Bonnie Huckabee Hackensmith*4. Sex *Female* 5. Color or race *white* 6. (a) Single, married, widowed, or divorced *Single*6. (b) Name of husband or wife *-*7. Birth date of deceased (mo., day, yr.) *Oct. 1 - 1873*8. AGE: Years *74* Months *1* Days *26* If less than one day
hrs. *0* min. *0*9. Birthplace *Frankfort Ky.*
(Town, county, and state)10. Usual occupation *Editorial Clerk Tariff Commission**Retired*

11. Industry or business

12. Name *John T. Hackensmith*13. Birthplace *Frankfort Ky.*14. Maiden name *Annie Mary Taylor*15. Birthplace *Franklin Co. Ky.*16. Informant *W.S.H. Records*Address *Frankfort Ky.*17. Burial (Burial, cremation, or removal. Which?) *Burial* Date thereof *11-28-47*
(month) (day) (year)

Cemetery or crematory

Location *Frankfort Ky.*18. Funeral director *J. H. Davis Co.*Address *2901-14th Street N.W. D.C.*19. Nov. 28 1947
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *D.C.*County *C.*City or town *Washington D.C.*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *4709* *8th st. N.W.*

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH *11/27* 1947 at *12:12 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11/16 1947, to *11/27* 1947and that I last saw her alive on *11/27* 1947Immediate cause of death *Multiple pulmonary embolism*

DURATION

*5 hours*Due to *Carcinoma of the stomach**? ?**Gastro-splenic ligament*Due to *?*Other conditions *Plural effusion - Aspirated**Sian hea Ca. of omentum*

(Include pregnancy within 8 months of death)

*Carcinoma of pancreas -**adhesis Plastica*Date of op. *January 1947*Autopsy results *Same as above*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

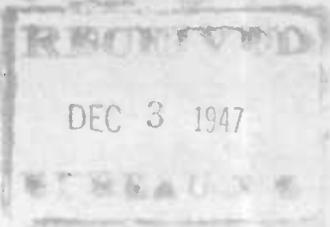
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE *Lionel Roth M.D.* M. D. or otherAddress *Washington Son. & Hospt.* Date signed *11/27/47**Takoma Park, Md.*

Registrar



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

CERTIFICATE OF DEATH

1018213
Reg. Dist. No.

1. PLACE OF DEATH:

County MONTGOMERY
City or town ROCKVILLE

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

CHESTNUT LODGE SANATORIUM.

Stay in hospital or Inst. (yrs., or mos., or days) 3 years, 8 months, 22 days.

Stay in this community (yrs., or mos., or days) life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County MONTGOMERY

City or town Darnestown

Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. None

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME

WILLIAM ALBERT JONES

4. Sex MALE Color or race WHITE 6.(a) Single, married, widowed, or divorced SINGLE.

6(b) Name of husband or wife None

7. Birth date of deceased (mo., day, yr.) May 7, 1857

8. AGE: Years Months Days If less than one day
90 90 6 6 - - - min.

9. Birthplace Darnestown, Maryland

(Town, county, and state)

10. Usual occupation FARMER (Retired)

11. Industry or business Farming

12. Name Z. Nathan Jones

13. Birthplace Montgomery Co., Maryland

14. Maiden name Eleanore West

15. Birthplace Montgomery Co., Maryland

16. Informant Miss Margaret Jones (Neice)

Address Darnestown, Maryland

17. Burial Date thereof Nov. 15, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Marys Churchyard

Location Rockville, Maryland

18. Funeral director W. Reuben Humphrey

Address Rockville, Maryland

19. Nov. 14, 1947
(Date rec'd by registrar) 2 P.M. Thompson
Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 13,

1947, at 6:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

OCT. 1, 1946, to NOV. 13, 1947,

and that I last saw him alive on NOV. 13, 1947.

Immediate cause of death

ACUTE HEART FAILURE. 15 min. DURATION

Due to ARTERIOSCLEROTIC HEART DISEASE 10 years

Due to SENILITY etc.

Other conditions DIABETES MELLITUS 10 years

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

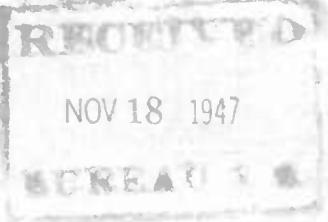
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE Joseph W. Cox, M.D. M. D. or other

Address Chestnut Lodge Date signed 11/13/47
Rockville, Md.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160a

10185

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County.....

Montgomery
Bethesda

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Life

Hospital, Institution, or street address where death occurred:

Suburban Hospital

life

How long in hospital or institution?.....

3. (a) FULL NAME

Infant Girl Joyce

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

None

7. Birth date of deceased (mo., day, yr.)

Nov. 7, 1947

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

17 Min.

0

0

hrs.

17 min.

9. Birthplace.....

Bethesda, Montgomery, Maryland

(Town, county, and state)

10. Usual occupation.....

None

11. Industry or business.....

None

12. Name.....

William Joyce

13. Birthplace.....

Scranton, Pennsylvania

14. Maiden name.....

Margaret Connell

15. Birthplace.....

Scranton, Pennsylvania

16. Informant.....

William Joyce

Address

Bethesda, Maryland

17. Burial.....

Date thereof... Nov. 8, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

St. Mary's Cemetery

Location.....

Rockville, Maryland

18. Funeral director.....

Wm. Redden Funeral Home

Address

Bethesda, Maryland

19. (Date rec'd by registrar)

11/7 1947

Wm E. Jones

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

City or town..... Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Maple Ridge Rd.

(If rural, give LOCATION)

2. (a) If veteran, name war..... None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

" / " / "

19 47 at 6:47 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11/7

19 47, to

11/7

19 47

and that I last saw her alive on.....

11/7

Immediate cause of death..... Respiratory failure

Due to..... Cerebral hemorrhage probable

Due to..... Placental, premature separation (Normal implantation)

Other conditions..... Chondrolymphatic

swelling.

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

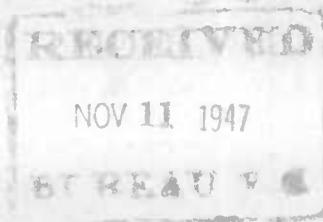
23. SIGNATURE.....

Alma B. Kelly, M.D.

M. D. or other

Address..... Silver Spring, Md.

Date signed..... 11/1947



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10186

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County... Montgomery
City or town... Rockville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... 3 years, 8 months

Hospital, Institution, or street address where death occurred:

Chestnut Lodge

How long in hospital or institution?... 3 years, 8 months

3. (a) FULL NAME

Ketchum, Georgina P.

4. Sex Female | 5. Color or race White | 6. (Single, married, widowed, or divorced) Widowed

6. (b) Name of husband or wife... ? Ketchum

7. Birth date of deceased (mo., day, yr.) Unknown | 8. (c) If alive, give age... years 1870

8. AGE: Years Months Days It less than one day
Approx. 97 6 mos. hrs. min.9. Birthplace Unknown
(Town, county, and state)

10. Usual occupation Secretary

11. Industry or business

12. Name PFLAUM

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Miss Evelyn Neumann

Address 1130 Park Ave. N.Y
(Distaff Cousin)
(Burial, cremation, or removal. Which?)17. Cremation Date thereof 11/28/47
(month/day/year)
Cemetery or crematory Cedar Hill Crematory

Location Washington, D.C.

18. Funeral director W.M. Remond Pennington
Address Rockville, Maryland19. 11-28 1947
(Date rec'd by registrar) E. Thompson
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Florida County PinellasCity or town St. Petersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. None

(If rural, give LOCATION)

2.(a) If veteran, name war No

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Nov 1947 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...
and that I last saw her alive on 27 Nov 1947

Immediate cause of death Cardiac insufficiency

DURATION

Due to arteriosclerotic changes
in blood vessels

Due to Senility

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Helen H. Eldred, M.D.
M. D. or otherAddress Chestnut Lodge
Rockville, Md.

Date signed 11-21-47

RECORDED

DEC 2 1947

U.S. GOVERNMENT PRINTING OFFICE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and legibly. is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1310

10187

CERTIFICATE OF DEATH

Reg. Dst. No. 218

1. PLACE OF DEATH:

County.....

City or town.....

Montgomery
germantown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

29 years

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Hilton S. Kirby

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Mary E. Kirby

6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.)

Feb - 2 - 1896

8. AGE:

Years Months Days If less than one day

71

9

10

hrs. min.

9. Birthplace

Briarcliff, Virginia

(Town, county, and state)

10. Usual occupation

Telegraph Operator

11. Industry or business

P. & O. Rail Road

MOTHER FATHER

12. Name

Miles Sibley Kirby

13. Birthplace

Montgomery - Va

14. Maiden name

Anna C. Gardner

15. Birthplace

Montgomery - Va

16. Informant

Mary E. Kirby

Address

Montgomery - Va

17. Burial

Date thereof 8/15/47

(Burial, cremation, or removal. Which?)

Cemetery or crematory Not retained.

Location Frederick road -

Funeral director Ernest G. Gaither

Address Fairthorpe Md

No. 12 1947 Alfred G. Cooke

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

Montgomery

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

705-12-3733

MEDICAL CERTIFICATION

20. DATE OF DEATH

Oct - 12 1947 at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April - 1 - 1947 to Oct - 12 - 1947

and that I last saw him alive on Nov - 11 - 1947

Immediate cause of death

Cardio-nephritis

Due to

Due to

Other conditions Chronic asthma

30 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William Miller, M.D.

M. D. or other

Address Butterburg, Md Date signed Nov. 12-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Distr. No. 217

10514

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County.....

Montgomery

City or town.....

Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

30 days

Hospital, Institution, or street address where death occurred:

Montgomery County General Hospital

How long in hospital or institution?.....

30 days

3. (a) FULL NAME

ALEX MACABEE

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

Negro

Married

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

March 20, unknown 1871

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Montgomery, Maryland
(Town, county, and state)

10. Usual occupation.....

None

11. Industry or business.....

None

MOTHER FATHER

12. Name..... John Macabee

13. Birthplace..... Montgomery, Maryland

14. Maiden name..... Helen Prother

15. Birthplace..... Montgomery, Maryland

16. Informant..... Hospital records

Address

17. Burial..... Date thereof..... Nov 24 - 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Brooke Grove Md

Location..... Montgomery Co Md

18. Funeral director..... Roy W. Barber

Address..... Cliftonville Md.

19. (Date rec'd by registrar) Nov 23 1947 Gwendolyn B. Lawler
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Montgomery

City or town..... Cliftonville
(If outside city or town limits, write RURAL and give nearest town)Street No..... Rural
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

2000

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... November 22, 1947 at 4 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 22, 1947, to November 27, 1947,

and that I last saw h... in alive on November 27, 1947.

Immediate cause of death.....

Carcinoma of Rectum
? months

Due to.....

Due to.....

Other conditions..... Hemangioid arteriole..... ? years
(Include pregnancy within 3 months of death)Major findings of operations..... Multiple metastases to
colon and peritoneum
Date of op. 10-47

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... PMB 1
M. D. or other

Address..... Sandy Spring, Md. Date signed 11/22/47

RECEIVED

DEC 22 1947

LIBRARY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10188

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

Colored

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age years

8. AGE:

Years
18Months
4Days
8It less than one day
hrs. min.

9. Birthplace

Towmish, Md

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Robert Martin

12. Name

Robert Martin

13. Birthplace

Md

14. Maiden name

Esther Mary

15. Birthplace

Md

16. Informant

Robert Martin

Address

Towmish, Md

17. Burial

Burial

Date thereof
(month) (day) (year)
Nov 26 1947

Cemetery or crematory

Tobytown, Md

Location

Towmish, Md

18. Funeral director

Robt. L. Snowden

Address

246 - N. Wash. St Rockville

19. 11-25-47

19

(Date rec'd by registrar)

Mrs. E. P. Thompson
Per Frank Stanley
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Montgomery

City or town

Tobytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 23

1947 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med Exam care to 19 19

and that I last saw h. alive on 18

Immediate cause of death

Extensive burns
Due to (accidental)Body found in state of home
which had completely burned
Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County) (State)

Injured at home, farm, industry, public place (where?)

Home

Means of injury

Fall

Injured at work? no

23. SIGNATURE

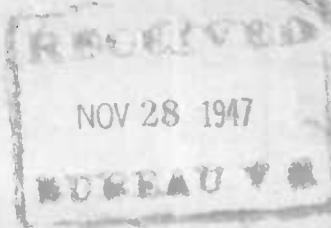
Frank J. Broadfoot M.D.

M. D. or other

Address

Self fed. Every 1/2 hour

etc. during bed Date signed 11-24-47



Adult Care Center
Senior Center

Alzheimer's

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10189

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County MONTGOMERY
City or town BETHESDA

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

5523 JOHNSON AVE

How long in hospital or institution?

3. (a) FULL NAME

PHILIP S. MATTHEWS

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife SARA BRANHAM

Aug 14 1883 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14, 1883

8. AGE: Years 64 Months Days If less than one day hrs. min.

9. Birthplace MIDLAND MICH
(Town, county, and state)

10. Usual occupation REALTOR

11. Industry or business

12. Name PHILIP S. MATTHEWS

13. Birthplace CANADA

14. Maiden name SARA HUGHES

15. Birthplace MICH

16. Informant Sara B. Matthews

Address 5523 Johnson Ave. Bethesda MD

17. Burial Date thereof 11 24 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Springfield Md.

18. Funeral director Jos. Hawley Funeral

Address 7956 Piney Ave. Wash. D.C.

19. 11/23 1947 Wm E Joles
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY

City or town BETHESDA (If outside city or town limits, write RURAL and give nearest town)

Street No. 5523 JOHNSON AVE (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

367-01-8076

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1947 at 8:20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1, 1947, to Nov 21, 1947 and that I last saw him alive on Nov 21, 1947

Immediate cause of death

Myocardial infarction

Due to Coronary thrombosis DURATION 14 hrs

Due to

Other conditions Hypertension DURATION 3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

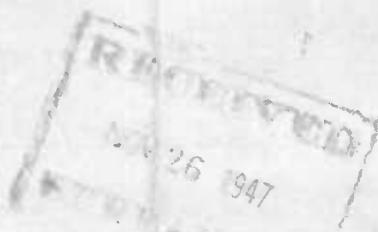
Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Ad Dayton MD M. D. or other

Address 2011 R St NW Date signed 1/21/47

Washington DC



H PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10190

93d
Reg. Diat. No. 216

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

4 hours

How long in above place of death?

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?

4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

D.C.

County.....

Washington

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 5736 3rd St., N.W.

(If rural, give LOCATION)

3. (a) FULL NAME

MC CONNELL, George Joseph

3. (b) Social Security Number

4. Sex

MALE

5. Color or race

Male

W-US

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Anna Francis McConnell

7. Birth date of deceased (mo., day, yr.)

July 4, 1881

6.(c) If alive, give age..... years

8. AGE:

Years
66Months
4Days
14

If less than one day

hrs.

min.

9. Birthplace

Mo.

(Town, county, and state)

10. Usual occupation

Motion Picture Operator

11. Industry or business

MOTHER FATHER

12. Name..... MC CONNELL, Thomas J. dec.

13. Birthplace

Mo.

14. Maiden name..... AUDRAIN, Elizabeth dec.

15. Birthplace

Ind.

16. Informant wife: Mrs. Anna F. McConnell

17. Address..... 5736 3rd St., N.W., Wash., D.C.

burial

Date thereof..... 11-21-47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... Arlington National Cemetery

Location..... Arlington, Virginia

18. Funeral director..... Hines Funeral Director..... W.A.S.

Address..... 2901 14th St., NW, Washington, D.C.

19. 11-18- 1947

(Date rec'd by registrar)

Mary C. Patterson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 18 November 1947 at 4:20P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18 November 1947 to 18 November 1947

and that I last saw him alive on 18 November 1947.

Immediate cause of death.....

Hypertensive Heart Disease

DURATION

several yrs.
2 daysDue to..... Broncho pneumonia

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... Hypertensive Heart Disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tell in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE.....

W. A. DINSMORE, Jr., Lt. Cdr. MC USN

M. D. or other

Address..... USNH Bethesda, Md.

Date signed..... 11-18-47

RECEIVED

NOV 20 1947

FEDERAL BUREAU OF INVESTIGATION

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10191

176

CERTIFICATE OF DEATH

216

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct language
is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hours 20 minutes

Hospital, institution, or street address where death occurred:

USNH, NNMC, Bethesda, Md., Maryland

How long in hospital or Institution? 6 hours 20 minutes

3. (a) FULL NAME

MC DONALD, Charles Rydolph

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

10-3-29

8. AGE:

Years
18Months
1Days
3

If less than one day

hrs.

min.

9. Birthplace Central Falls, Rhode Island

(Town, county, and state)

10. Usual occupation U.S. Navy

11. Industry or business

12. Name Charles McDonald

13. Birthplace Rhode Island

14. Maiden name Gladys Irene Lazotte

15. Birthplace Rhode Island

16. Informant father: Mr. Charles McDonald

Address 6 Perry St., Central Falls, R.I.

17. Burial Date thereof (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory Notre Dame

Location Pawtucket, Rhode Island

18. Funeral director W. W. Chambers Co.

Address 1400 Chapin St. NW, Washington, D.C.

19. 47 Mary C. Patterson
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Rhode Island

County

City or town Central Falls

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6 Perry Street

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 November 1947 at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Def. Med. Sear Co., to 19.....
and that I last saw h. alive on 19.....

Immediate cause of death.....

Fracture of skull

Due to.....

fall from tractor

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 11-29-47

Where did injury occur? Anacostia DC. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) N.A.S.

Means of Injury Fall

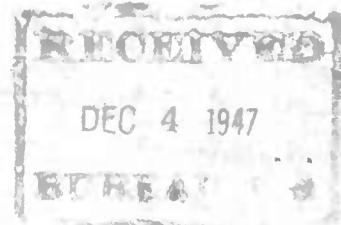
Injured at work? Yes

23. SIGNATURE.....

Frank J. Borchard M.D.
Seybold Team

M. D. or other

Address Yonkers, N.Y. Date signed 11-30-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

838
10192

CERTIFICATE OF DEATH

Reg. Distr. No. 223

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

#1 Takoma Avenue

How long in hospital or institution?

3. (a) FULL NAME

DANIEL MILLER

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MaleWhiteMarried

6.(b) Name of husband or wife

Mabel H. Miller

7. Birth date of deceased (mo. day, yr.)

July 5, 1861

6.(c) If alive, give age years

8. AGE:

Years 86Months 4Days 5If less than one day
hrs. min.

9. Birthplace

Oakland, Maryland

(Town, county, and state)

10. Usual occupation

Rural U.S.P.O. Employee

11. Industry or business

Government

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Mrs. Mabel H. Miller

Address

#1 Takoma Ave, Takoma Park, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov 13, 1947
(month) (day) (year)

Cemetery or crematory

Rock Creek Cemetery

Location

Rock Creek Church Rd, Washington, DC

18. Funeral director

J. Arthur Walter

Address

254 Canoe St New Jaff. L. C.

19. (Date rec'd by registrar)

Nov 11, 1947

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md

County

MontgomeryCity or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. #1 Takoma Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Nov 10

19X.7

at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1st seen care
and that I last saw h. alive on 19, to 19.

Immediate cause of death

Cerebral embolism

DURATION

2 1/2 hr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

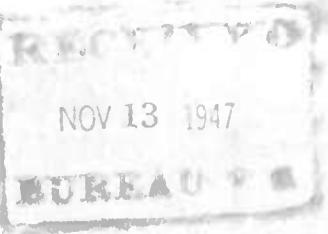
23. SIGNATURE

Frank J. Brochart M.D.Expedited Exam.

M. D. or other

Address

Yachtway RdDate signed 10-10-57



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10193

CERTIFICATE OF DEATH

216

Reg. Dist. No.

458

1. PLACE OF DEATH: Montgomery
County.....
City or town..... Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 6 months, 10 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution?..... 6 months, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... D.C. County..... Washington
City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 803 7th St., N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war..... WWI

3. (a) FULL NAME
MORAN, Martin Aloysius

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) September 5, 1894

8. AGE: Years 53 Months 1 Days 29 If less than one day .hrs. .min.

B. Birthplace..... Washington, D.C.
(Town, county, and state)

10. Usual occupation..... unemployed

11. Industry or business

MOTHER FATHER
12. Name..... MORAN, Cornelius dec
13. Birthplace..... Ireland, C.

MOTHER FATHER
14. Maiden name..... DONOUGH, Katherine dec

15. Birthplace..... Wash., D.C.

16. Informant..... sister: Mrs. Mary A. Baness

Address..... 803 7th St., N.E., Wash., D.C.

17. burial Date thereof..... 11-8-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mt. Olivet

Location..... Washington, D.C.

18. Funeral director..... Hanlon Funeral Home W.A.R.

Address..... 611 H St., N.E., Wash., D.C.

19. 11-5 47
(Date rec'd by registrar) Mary C. Patterson
Mary C. Patterson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 11 1947 at 12:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24 1947 to Nov. 19 47
and that I last saw him alive on November 4 1947

Immediate cause of death..... massive air embolism Duration minutes
Due to..... Rupture right external carotid artery 2 hrs
Due to..... erosion; probably from irradiation 2 hrs
Other conditions..... Carcinoma, tongue 1 yr. 2 mos.

(Include pregnancy within 8 months of death)

Major findings or operations..... Carcinoma, base of tongue & right ant. pharynx Date of op.
Ante mortem results..... erosion at rt. carotid C. necrosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of...

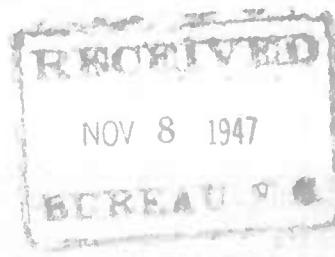
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... A. J. DELANEY Capt. MC USN
M. D. or other

Address..... USNII Bethesda, Md. Date signed 11-5-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10194

195
Reg. Dist. No.

216

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Montgomery

City or town

Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Since 10-26/47

Hospital, institution, or street address where death occurred:

Autumn Hop
6600 Old Georgetown Rd.
Bethesda

How long in hospital or institution?

3. (a) FULL NAME

Edw. Mullinix

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

Edith Mullinix

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age .. years

1875

8. AGE:

72

72

1

30

Days It less than one day

hrs.

min.

9. Birthplace

Montgomery County, Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Farming

MOTHER FATHER

James E. Mullinix

James E. Mullinix

Cedar Grove, Maryland

Cedar Grove, Maryland

Cedar Grove, Maryland

Cedar Grove, Maryland

16. Informant

Ada Main

Address

Cedar Grove, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Nov. 13, 1947

(month) (day) (year)

Cemetery or crematory

Salesen Cemetery Cemetery

Location

Cedar Grove, Md.

18. Funeral director

Roy W. Parker

Address

Taylorville, Md.

19. Date rec'd by registrar

11/11/47

1947

Date signed

John E. Jones

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Montgomery

City or town Cedar Grove

(If outside city or town limits, write RURAL and give nearest town)

Street No. 257

Drakefield

(If rural, give LOCATION)

2.(a) If veteran, name war

US

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

11/11/47

1947, 216, 25, A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19...

to

and that I last saw him alive on

Immediate cause of death

DEP MED EXAM CASE

Autopsy, Much blood

Pls sign for Report

19...

19...

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

Much blood

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Accident

Date of 10/26/47

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

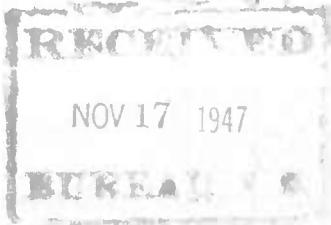
Injured at work?

23. SIGNATURE

Approved Path

M. D. or other

Banky Spring Md. Date signed 11/11/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10195

216

CERTIFICATE OF DEATH

Reg. Dist. No. 94a

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda, (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Mo. 21 days

Hospital, Institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 Month, 21 days

3. (a) FULL NAME

OSBORN, Solomon (n)

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

W-US

married

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years
June 22, 1873

8. AGE: Years

Months

Days

If less than one day

74

5

2

hrs.

min.

9. Birthplace..... W. Va.

(Town, county, and state)

10. Usual occupation..... Farmer

11. Industry or business

12. Name OSBORN, Solomon d.o.c.

13. Birthplace Va.

14. Maiden name. NICHOLS, Sue dec.

15. Birthplace Va.

16. Informant wife: Mrs. Pearl Osborn, The Plains,

Address Virginia

17. burial

(Burial, cremation, or removal. Which?) Date thereof. (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director W. W. CHAMBERS.

Address 3072 M St., N.W., Wash., D.C.

11-25 1947 Mary C. Patterson

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Va.

County.....

City or town..... The Plains

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)
WWI & Sp.Am.

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 November 1947 at 11:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 3 1947 to 24 Nov. 1947

and that I last saw h. im. alive on 24 November 1947

Immediate cause of death CORONARY THROMBOSIS AND CEREBRAL INFARCTION AND ABSCESS

DURATION 2 week

Due to.....

Due to.....

Other conditions

BRONCHOPNEUMONIA BILATERAL

(Include pregnancy within 3 months of death)

Major findings of operations..... CALCULUS URINARY BLADDER

Date of op.

Autopsy results CEREBRAL INFARCTION AND ABSCESS

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where)

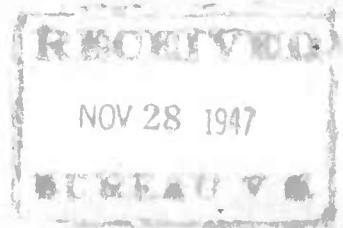
Means of injury T. N. Quilter Injured at work?

23. SIGNATURE..... T. N. QUILTER, Lt. JG MC USNR

M. D. or other

Address USNH Bethesda, Md.

Date signed 11-25-47



NOV 28 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

161c

10196

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban HospitalHow long in hospital or institution? 16 hours and 10 mins

3. (a) FULL NAME

Earl Palmer.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

Negro single

6.(b) Name of husband

Charles Henry Wilson6.(c) If alive, give age 20 years

7. Birth date of deceased (mo. day, yr.)

November 8, 1947

8. AGE:

Years	Months	Days	If less than one day
		7	9 hrs. 10 min.

9. Birthplace

Bethesda, Montgomery Co., Md.
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

Charles Henry Wilson

12. Name

Charles Henry Wilson

13. Birthplace

Scotland, Maryland

14. Maiden name

Marquenie Palmer

15. Birthplace

Washington, D.C.

16. Informant

Mother - Marquenie Palmer

Address

Box 5822, Bethesda, Maryland

17. Cemetery or crematory

Cremation Date thereof Nov 19 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Suburban Hospital

Location

Bethesda 14 md

18. Funeral director

A. B. Solow / supt

Address

Bethesda 14 md

19. (Date rec'd by registrar)

11/24 1947Tom E. Jones

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. Weaver's Farm Bell mills Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1947 at 4:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on

Immediate cause of death

Cryothrombosis
Fatals.

DURATION

Due to.....

Due to.....

Other conditions Dehydration
anemia

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE Donald M. Kaback

M. D. or other

Address 5802 1/2 Corn Ave Date signed 11/20/47
Washington, D.C.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

518

10197

Reg. Dist. No. 216

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County MONTGOMERY

City or town BETHESDA

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred SUBURBAN
HOSPITAL - 8600 OLD GEORGETOWN Road

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 629 Silver Spring Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

3. (a) FULL NAME

MERTON PEARRE

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife

HALLIE N PEARRE

7. Birth date of deceased (mo., day, yr.)

NOVEMBER 20, 1871

6.(c) If alive, give age years

8. AGE:

Years 75

Months 11

Days 19

If less than one day

hrs. min.

9. Birthplace

UNIONVILLE, MARYLAND

(Town, county, and state)

10. Usual occupation

PHYSICIAN

11. Industry or business

WILLIAMS H. PEARRE

MOTHER FATHER

UNIONVILLE, MARYLAND

12. Name

RUTH BUCKINGHAM

13. Birthplace

ARROLL COUNTY, MARYLAND

14. Maiden name

WIFE MRS. HALLIE N. PEARRE

15. Birthplace

629 SILVER SPRING AVE., SILVER SPRING, MD

16. Informant

BROTHA

17. (Burial, cremation, or removal, which?)

Date thereof 11-4-47

(month) (day) (year)

Cemetery or crematory

LINGTON

18. Funeral director

C. M. WALK

Address

UNIVERSITY HOSPITAL

19. (Date rec'd by registrar)

11-2-1947

11-5-1947

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1947 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 29 1947 to Nov. 1 1947

and that I last saw him alive on Nov. 1 1947

Immediate cause of death

CEREBRAL HEMORRHAGE 3 days

Due to

Due to

Other conditions CARCINOMA OF PROSTATE

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE DR. Major Basshead M.D. M. D. or other

Address 19601 Button St. Silver Spring, Md. Date signed 11/2/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10198

159

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County MONTGOMERY

City or town OLNEY

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:

The MONTGOMERY COUNTY GENERAL HOSPITAL

How long in hospital or institution? 10 days

3. (a) FULL NAME

Baby girl DYSAN

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Colored

Single

MEDICAL CERTIFICATION

6. (b) Name of husband or wife

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 6, 1947

8. AGE:

Years

Months

Days

If less than one day

10 hrs. min.

9. Birthplace OLNEY, MONTGOMERY MARYLAND

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name RUSSELL PLUMMER

13. Birthplace Stewartstown, Maryland

14. Maiden name MARGARET LAUREN DYSAN

15. Birthplace Gaithersburg, MARYLAND

16. Informant MARGARET LAUREN DYSAN

Address Gaithersburg, MD. R #2

17. Burial Date thereof Nov (month) (day) (year)

(Burial, cremation, or removal. Which?)

Brookside Cemetery

Cemetery or crematory

Laytonsville, Md

Location

Roy W. Barber

18. Funeral Director

Laytonsville, Md

Address

Nov 15-1947

(Date rec'd by registrar)

Gertrude B. Lawler

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY

City or town Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. #2

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1947 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

NOVEMBER, 1947, to November 15 1947

and that I last saw her alive on Nov. 15 1947

Immediate cause of death

Depression of Respiratory Center

Due to ? cerebral edema

DURATION

8 hours

8 hours

10 days

Due to Prematurity

Other conditions Pregnancy of mother

10 days

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

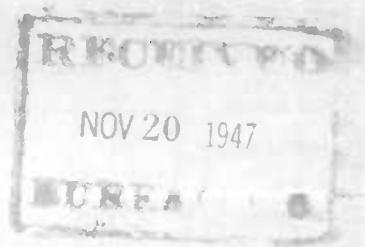
Means of injury

Injured at work?

23. SIGNATURE

Charles H. Ligon, M.D. or other

Address Sandy Spring, Md Date signed 11/15/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10199

93d Reg. Dist. No. 216

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County MONTGOMERY
City or town CHEVY CHASE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 YEARS
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

LE ROY ATKINS PORTER

3. (b) Social Security Number

4. Sex

5. Color or race

8.(a) Single, married, widowed, or divorced

MALE WHITE MARRIED

6.(b) Name of husband or wife

RUSSELL PORTER

7. Birth date of deceased (mo., day, yr.)

SEPT 17 1883

(c) If alive, give age years

8. AGE:

Years 64

Months

Days

If less than one day

hrs. min.

9. Birthplace

JACKSONVILLE, ALABAMA

(Town, county, and state)

10. Usual occupation

INTER STATE COMM COMM

11. Industry or business

MOTHER FATHER

CHRISTOPHER J. PORTER

ALA

14. Maiden name

ANNIE T. PRIVETT

ALA

16. Informant

MR. LE ROY A PORTER JR.

Address

6503 CONN. AVE, CHEVY CHASE

Removal

Date thereof Dec 1, 1947

(month) (day) (year)

Cemetery or crematory

Location

Jacksonville, Alabama

18. Funeral director

W.W. Chamber Co

Address

3072 M ST NW Washington DC

19. (Date rec'd by registrar)

12/1 1947

Am Jules

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County MONTGOMERY

City or town CHEVY CHASE

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6503 CONN AVE

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Nov. 30th 1947 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Past 10 years 19 11/30 1947

and that I last saw him alive on week of 11/17 1947

Immediate cause of death Pulmonary Edema

Acute cardiac decompensation 11 hours

Due to chronic hypertension

& arteriosclerosis 10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 11-1016-11-25 Date signed 11/30/47 over

by 10pm on Dec 8/47

Patient was dead on arrival

Patient was seen alive in my D.C. office during month of 11/17/47. He had been under frequent care for by physician during the past few years.

Case was cleared through Police and Coroner's Office by Phone.

W. S. Blunk

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10200

50

CERTIFICATE OF DEATH

Reg. Dist. No.

714

1. PLACE OF DEATH:

County... Montgomery

City or town... Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

XXXXXX
Residence, not street address where death occurred.
9104 Colesville Road

How long in hospital or institution?

3. (a) FULL NAME

MRS. MARY WALKER PRENTISS

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female white married

6. (b) Name of husband or wife... Fred R.

7. Birth date of deceased (mo., day, yr.) June 27th. 1897 6. (c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
49 4 18 hrs. min.9. Birthplace... Ohio
(Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business

12. Name... William H. Walker

13. Birthplace... Ohio

14. Maiden name... Mary Alice Kress

15. Birthplace... Ohio

16. Informant... Mr. Fred R. Prentice

Address 9104 Colesville Rd. Sil. Spg.

17. Burial Date thereof Nov. 17th. 47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Fort Lincoln

Location... Prince Georges Co., Md.

18. Funeral director... Davies & B. Murphy

Address Silver Spring, Md.

19. Nov. 17 1947
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery

City or town... Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 9104 Colesville Road
(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1947 at 10^{15a.m.}

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 1946 to Nov. 15 1947
and that I last saw her alive on Nov. 14-47 11.30pm.

Immediate cause of death... pneumonia

DURATION

Due to... Ca of Breast

Due to... with Metastases to
lung + liver

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations... 1943 Cancer of
left Breast Date of op. Feb.

Autopsy results... S. B. L. C. h. o. p.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

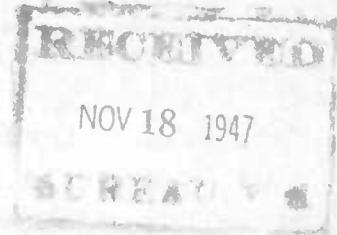
Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub'l'c place (where?)

Means of injury... Injured at work?

23. SIGNATURE... Richard B. Phillips M.D.
M.D. or other
Address 8248 Georgia Ave
Silver Spring, Md.
Date signed 11-15-47



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10201

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 55 yrs.
Hospital, institution, or street address where death occurred:
8605 Burdette Road,
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda 14,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8605 Burdette Road,
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME

* * * * * ELIZA CLARK PUGH * * *

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced			
Female	White	Widowed			
6.(b) Name of husband or wife Charles Pugh (deceased)					
7. Birth date of deceased (mo., day, yr.) December 13, 1859					
6.(c) If alive, give age years					
8. AGE:	Years 87	Months 87	Days 11	If less than one day 13	- hrs. - min.

9. Birthplace Virginia
(Town, county, and state)
Housewife

10. Usual occupation None
11. Industry or business None

12. Name John Phillips
13. Birthplace Virginia

14. Maiden name Matilda Golispie
15. Birthplace Virginia

16. Informant Mr. Richard E. Pugh (son)
Address Bethesda 14, Maryland

17. Burial Date thereof Nov. 28, 1947
(Burial, cremation, or removal. Which?)
Cemetery Bethesda Presbyterian church
Location Bethesda, Maryland

18. Funeral director Wm. F. Leaden Pumphrey
Address Bethesda 14, Maryland

19. 11-27-47 19.....
(Date rec'd by registrar)

Am 5 Jule
Registrar

3. (b) Social Security Number
None

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26th, 1947 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 18, 1947 to Nov. 26, 1947
and that I last saw her alive on Nov. 26, 1947.

Immediate cause of death Cardiac insufficiency
Due to Our generalized arterio-
sclerosis 10 yrs.

Due to
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE

Enil G. Baumfeld, M.D. or other

7345 Wisconsin Ave., Address Bethesda, Maryland Date signed 11/26/47

RECEIVED

NOV 29 1947

LIBRARY

PLEASE WRITE PLAINLY, WITH ENFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

518

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 months, 27 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 months, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C. County.....

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1901 Tilden St., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war..... WWI

3.(a) FULL NAME

RAINIER, Norman

3.(b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

W-US

married

6.(b) Name of husband or wife.....

Rosita Rainier

7. Birth date of deceased (mo., day, yr.)

November 6, 1888

6.(c) If alive, give age..... years

8. AGE: Years

Months

Days

If less than one day

59

0

8

hrs.

min.

9. Birthplace.....

England

(Town, county, and state)

10. Usual occupation.....

Retired Marine Corps

11. Industry or business

MOTHER FATHER

12. Name..... RAINIER, Nelson K. dec.

13. Birthplace.....

England

14. Maiden name.....

Florence

? dec.

15. Birthplace.....

England

16. Informant.....

Wife: Mrs. Rosita Rainier

Address.....

1901 Tilden St., N.W., Wash., D.C.

17. Burial

Date thereof..... 11-18-47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Arlington National

Location.....

Arlington, Va.

18. Funeral director..... S. H. HINES

Address..... 2901 14th St., N.W., Wash. D.C.

19. (Date rec'd by registrar)

11-14- 1947

Mary C. Patterson

Mary C. Patterson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

14 November

1947

at 11:39 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

17 April

1947

to 14 Nov.

1947

and that I last saw h..... im. alive on

14 November

1947

Immediate cause of death.....

Cardiac Failure

DURATION

3 months

Due to..... Coronary Heart Disease

5 yrs+

Date..... Carcinoma Prostate
with metastasis to liver

?

Other conditions..... Left hydronephrosis

1 yr.

Pulmonary infarction

1 mo.

(Include pregnancy within 6 months of death)

Major findings or operations.....

Date of op.

Autopsy results..... Carcinoma Prostate, coronary thrombosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: NO

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

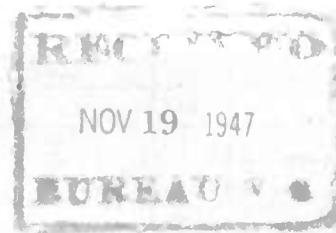
23. SIGNATURE.....

Philip J. Bates

M. D. or other

Address..... USNH Bethesda, Md.

Date signed..... 11-14-47



1405-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

108

10203

CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Montgomery
City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mrs. Martha Agnes Reeves

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Fe	White	Married

8. (b) Name of husband or wife James C. Reeser

8. (c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) April 17 1864

8. AGE: Years	Months	Days	If less than one day
83	6	25	hrs. min.

9. Birthplace Virginia

(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

12. Name William Fraser

13. Birthplace Virginia

14. Maiden name Martha Howison

15. Birthplace Virginia

16. Informant Mr. Wallace Reeves

Address Silver Spring Md.

17. Burial Date thereof Nov. 15 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Suitland Md.

18. Funeral director William Fraser Sons

Address 300-4th St. N.E. Wash. D.C.

19. Nov. 17 Date rec'd by registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No Burnt Mills Hall

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1947 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 4 1947 to Nov. 12 1947

and that I last saw her alive on Nov. 12 1947

Immediate cause of death pneumonia, lobar

DURATION 4 days

Due to Multiple Sclerosis

Several months

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John N. Andrew M.D.

(601 Colesville Rd) M. D. or other

Address Silver Spring Md. Date signed 11-12-47

RECEIVED

NOV 14 1947

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10529

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County Montgomery

City or town Potomac

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, institution, or street address where death occurred:

Rockville, R.F.D. #2

How long in hospital or institution? None

3. (a) FULL NAME

Ira Sylvester Ricketts

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Elizabeth S. Ricketts

7. Birth date of deceased (m., day, yr.) December 4, 1888

8. AGE: Years Months Days If less than one day
58 11 26 hrs. min.9. Birthplace Potomac, Maryland
(town, county, and state)

10. Usual occupation Carpenter

11. Industry or business None

12. Name Edward C. Ricketts

13. Birthplace Potomac, Maryland

14. Maiden name Leeanna Baker

15. Birthplace Unknown

16. Informant Mrs. Elizabeth S. Ricketts

Address Potomac, Maryland

17. Burial Date thereof Dec. 4, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rockville Union Cemetery

Location Rockville, Maryland

18. Funeral director Wm. Reuben Humphrey

Address Bethesda, Maryland.

19. 12 - 7 1947
(Date rec'd by registrar)20. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Potomac
(If outside city or town limits, write RURAL and give nearest town)Street No. Rockville, R.F.D. #2
(If rural, give LOCATION)

2. (a) If veteran, name war None

3. (b) Social Security Number

Yes-Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30, 1947, at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. med. Etain care 19 to 19
and that I last saw h. alive on 19

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

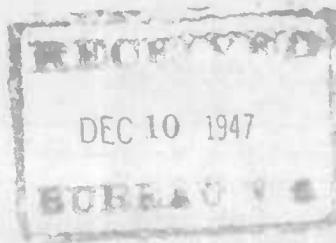
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank J. Borchard M.D.
Address 1000 Rockville Rd. Date signed 1947

M. D. or other





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

10512

213

Reg. Dist. No.

1. PLACE OF DEATH:
County... Montgomery
City or town... Potomac
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.... 10 years
Hospital, institution, or street address where death occurred:
R.F.D. #2 Rockville,
None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State... Maryland County... Montgomery
City or town... R.F.D. #2, Rockville (Potomac)
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. #2
(If rural, give LOCATION)
2.(a) If veteran, name war... None

3. (a) FULL NAME

***** NINA DOVE SAUNDERS *****

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife... James H. Ricketts

7. Birth date of deceased (mo., day, yr.) November 10th, 1876

8. AGE: Years	Months	Days	If less than one day
71	71	0	20
			hrs. min.

9. Birthplace... Leesburg, Virginia
(Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business... None

12. Name	Jack Dove
13. Birthplace	Virginia

14. Maiden name... Elizabeth Poole

15. Birthplace... Virginia

16. Informant... Mrs. Elizabeth S. Ricketts

Address RFD#2, Rockville, Maryland

17. Burial... Date thereof... Dec. 4, 1947
(Burial, cremation, or removal. Which?)

Cemetery or crematory... Rockville Union Cemetery

Location... Rockville, Maryland

18. Funeral director... Wm. Henderson Thompson

Address Bethesda, Maryland

19. 12 - 4 1947
(Date rec'd by registrar)DR Thompson
Registrar3. (b) Social Security Number
None

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30th 1947 at 8:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. fo.

19.

and that I last saw h alive on

19.

Immediate cause of death

DEP. MED. EXAM. CASE

DURATION

Died suddenly

Due to... Acute cardiac Dilatation

Instant

Due to... Chronic myocarditis

?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results... As shown above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide...

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Dr. B. J. Thompson
Address Sandy Spring, Md. Date signed 12/1/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10204

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 month, 22 days

Hospital, Institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution?..... 1 month, 22 days

3. (a) FULL NAME

SHANK, Norman Harold

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife..... Mrs. Dorothy M. Shank

6.(c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)..... 1 April 1903

8. AGE: Years	Months	Days	If less than one day
44	7	6	hrs. min.

9. Birthplace..... West Virginia
(Town, county, and state)

10. Usual occupation..... unknown

11. Industry or business..... unknown

12. Name..... Michael Shank

13. Birthplace..... Pennsylvania, deceased

14. Maiden name..... Daisy Butts

15. Birthplace..... Virginia, deceased

16. Informant..... Wife: Mrs. Dorothy M. Shank

Address..... Edgewater, Maryland

17. burial..... Date thereof..... 11-21-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Arlington National Cemetery

Location..... Arlington, Virginia

18. Funeral director..... W. W. Chambers Co. W.W.C.

Address..... 1400 Chapin St., NW, Washington, D.C.

19. 11-8 1947 Mary C. Patterson
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County..... An Ar.

City or town..... Edgewater

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

WW II

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 7 November 1947 at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-16-1947 to 11-7-1947 and that I last saw him alive on 11-7-1947.

Immediate cause of death.....

Sudden Severe Coronary Occlusion

DURATION

5 min

Due to.....

Coronary Insufficiency (Angina Pectoris)

1 year

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

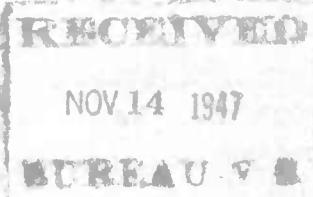
Means of injury..... H. L. C. Stevens, Jr. Injured at work?

23. SIGNATURE..... H. L. C. STEVENS, JR., LT/G MC USNR

M. D. or other

Address..... USNH, Bethesda, Md.

Date signed 11-8-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

10206

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda, (rural)

(If outside city or town limits, write RURAL and give nearest town)

20 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution?

20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D. C.

County.....

Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 805 Quackenbos Street, Northwest

(If rural, give LOCATION)

2.(a) Is veteran, name war..... WW I

3. (b) Social Security Number

3. (a) FULL NAME

SHOR, Louis (n)

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife..... Sarah Shor

7. Birth date of deceased (mo., day, yr.)..... 10 June 1897

8. AGE: Years	Months	Days	It less than one day
50	5	20	hrs. min.

9. Birthplace..... Austria
(Town, county, and state)

10. Usual occupation..... unknown

11. Industry or business

12. Name..... Hyman Shor

13. Birthplace..... Austria, deceased

14. Maiden name..... Hannah Laufer

15. Birthplace..... Austria, deceased

16. Informant..... Wife: Mrs. Sarah Shor

Address 805 Quackenbos St., NW, Washington, D.C.

17. Burial..... Date thereof..... 12-1-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... George Washington Memorial

Location..... Maryland

18. Funeral director..... Goldberg Funeral Home C. H.

Address 4217 9th St., NW, Washington, D.C.

19. 12-1-47..... 19..... Mary C. Patterson
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 30 November 1947 at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
11-10-..... 1947, to 11-30-..... 1947

and that I last saw h. 1m alive on 11-30-..... 1947

Immediate cause of death..... Coronary clufractio

Due to..... Coronary occlusion

Due to..... Hypertension Cordio
vascular diseaseOther conditions..... Acidosis + exsanguination
rather long during hypertension [1/4-1/2 hrs.]

(Include pregnancy within 3 months of death)

Major findings or operations..... Date of op.

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

10 E Billman

23. SIGNATURE..... D. E. BILLMAN, LTJG MC USN
M. D. or other

Address..... USNH, Bethesda, Md. Date signed..... 12-1-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10205

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

Montgomery

County

Bethesda (rural)

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C.

County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 481 L.S. S.W.

(If rural, give LOCATION)

2.(a) If veteran, name war WWI

3.(a) FULL NAME

SIMON, Andrew (n)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo. day. yr.) July 5, 1893

8. AGE: Years	Months	Days	If less than one day
54	4	21	hrs. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual occupation unemployed

11. Industry or business

12. Name Simon, Eli dec.

13. Birthplace S.C.

14. Maiden name Cool, Sally dec.

15. Birthplace S.C.

16. Informant sister-in-law: Mrs. Agnes Smalls

Address 481 L St., S.W., Wash., D.C.

removal Date thereof 11-26-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Bishopville, S.C.

18. Funeral director Barnes & Matthews

Address 612-614 Fourth St., S.W., Wash., D.C.

11-26 47 Mary C. Patterson

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1947 at 9:25A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

23 November 1947 to 26 November 1947

and that I last saw h. im. alive on November 26 1947

Immediate cause of death

Lobar Pneumonia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results Lobar Pneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

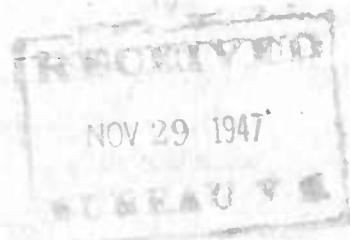
R. L. FLECK

Injured at work?

23. SIGNATURE R. L. FLECK, Lt. MC USN M. D. or other

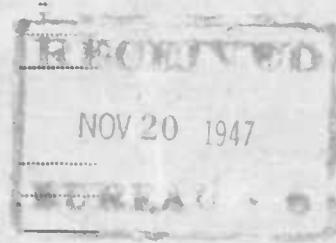
USNH Bethesda, Md.

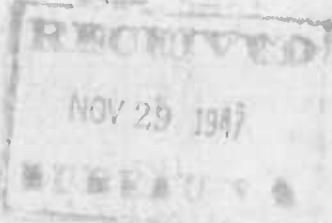
Address 11-26-47 Date signed



NOITAF

NOITAF







PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10209
309

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

left

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

C

married

6. (b) Name of husband or wife

Jennette Snowden

7. Birth date of deceased (mo., day, yr.)

June 7 1888

6. (c) If alive, give age ... 53 years

8. AGE:

Years 59

Months X 5

Days

If less than one day

hrs.

min.

9. Birthplace

9. Married, Maryland

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

George R. Snowden

12. Name

George R. Snowden

13. Birthplace

Hagerstown, Md.

14. Maiden name

Alice Fisher

15. Birthplace

Baltimore, Md.

16. Informant

Jennette Snowden (wife)

Address

Norbeck, Maryland

17. Burial

Burial Date thereof Nov 14 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Church Cemetery

Location

Norbeck, Maryland

18. Funeral director

R. L. Snowden

Address

246 N. Walsh St., Rockville

19. Nov. 14

1947 Gertrude B. Lawrence

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....

Maryland County.....

City or town.....

Norbeck

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 1947 at 9:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 8 1946 to Nov 11 1947

and that I last saw him alive on Nov 11 1947

Immediate cause of death

Coronary Thrombosis

DURATION

Due to Embolus

Due to Gastric Gastroenteritis

Other conditions Chronic Myocarditis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

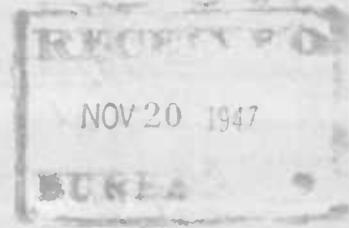
M. D. or other

Address

Norbeck Md

Date signed

Nov 12 1947



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10210

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County.....

City or town.....

Montgomery
Glenelg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 day

Hospital, institution or street address where death occurred: Montgomery County Genl Hosp.

How long in hospital or institution? 29 day

3. (a) FULL NAME

CHARLES E.

STEPHENS

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Max. 22, 1867

6.(c) If alive, give age..... years

8. AGE: Years

80

Months

37

Days

26

It less than one day

hrs.

min.

9. Birthplace.....

(Town, county, and state)

Va.

10. Usual occupation.....

Retired

11. Industry or business.....

Farmer

MOTHER

FATHER

12. Name..... CHARLES E. STEPHENS

13. Birthplace.....

Va.

14. Maiden name.....

Nora B Talbott

15. Birthplace.....

Frederick Co., Md.

16. Informant.....

Hospital Records

Address

Sandy Spring, Md.

17. Burial.....

Date thereof Nov. 21, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Montgomery Co.

Location.....

Montgomery Co.

18. Funeral director.....

John Glenburn Lumpshay

Address.....

Bethesda, Maryland

Nov. 18

19. 47

Sandy Spring, Md.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Brentwood

Montgomery

City or town.....

Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

RFD #1

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Nov. 18

19. 47

P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 27, 1947, to Nov. 18, 1947,

and that I last saw him alive on Nov. 18, 1947.

Immediate cause of death.....

Cerebrovascular accident + coronary Occlusion

Due to Arteriosclerotic Heart Disease

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

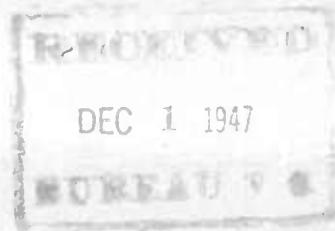
Injured at work?

23. SIGNATURE.....

Charles W. Liggin, M.D.

M. D. or other

Address..... Sandy Spring, Md. Date signed 11/18/47



PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. If incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157f

10211
223

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Montgomery Co.City or town Takoma Park Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days & 4 hr 55 min.

Hospital, institution, or street address where death occurred:

Washington Sanitarium HospitalHow long in hospital or institution? 5 days & 4 hr 55 min.

3. (a) FULL NAME

Douglas Lee Stevens

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

6.(b) Name of husband or wife

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.)

November 4. 1947

8. AGE:

Years

Months

Days

It less than one day

5 4 hrs. 55 min.

9. Birthplace

Washington San. Hosp. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

Douglas Carlton Stevens

13. Birthplace

Rockville Md.

14. Maiden name

Martha Virginia Dawson

15. Birthplace

MontgomerySan. Records.

Address

Burial Cremation Date thereof Nov. 16 1947
(Burial, cremation, or removal. Which?) (month (day) year)

Cemetery or crematory

Takoma Park Mem. Cem.

Location

Riggs Park

18. Funeral director

J. Arthur Miller

Address

754 Laurel St., Takoma Park, Md.

19. (Date rec'd by registrar)

Nov. 11 1947

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty MontgomeryCity or town Bethesda, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. Residence #2

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

November 9 1947 at 10 55 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 41947Nov. 91947and that I last saw him alive on Nov. 919471947Immediate cause of death PrematurityPatent ductus arteriosus
Amniocetle

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations Amniocetle - unable to completely replace viscera - ABD. wall lacking Date of op. 11-4-47Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

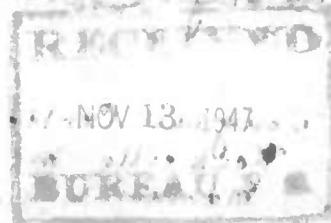
Injured at work?

23. SIGNATURE

Emma Hughes M.D.

M. D. or other

Address Takoma Park Md. Date signed 11-10-47





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

10212

218

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County MontgomeryCity or town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Walter Henry Stewart4. Sex Male 5. Color or race col. 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife house Stewart6.(c) If alive, give age 28 years7. Birth date of deceased (mo., day, yr.) January 21 19178. AGE: Years 33 Months 10 Days 8 If less than one day hrs. min.9. Birthplace Gaithersburg, Maryland
(Town, county, and state)10. Usual occupation Janitor

11. Industry or business

12. Name Richard Henry Stewart13. Birthplace Gaithersburg, Md.14. Maiden name Pachel Pacey15. Birthplace Gaithersburg, Md.16. Informant Almeida Wims - SisterAddress Gaithersburg, Md.17. Burial Burial Date thereof Dec 2, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Brooke GroveLocation Laytonsville, Md.18. Funeral director R. L. InsuransAddress 246 N. Wash. St. Rockville19. 12/2 Date rec'd by registrar 1947

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)Street No. P.T.D. #1 Streettown Stewartown

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1947 a.m. 11:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

def med brain case 19 to 19

and that I last saw h. alive on 19

Immediate cause of death

fracture of 2nd cervical vertebra and crusting killeddue to chest with inter thoracic hemorrhage intensitydue to auto accident 7

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

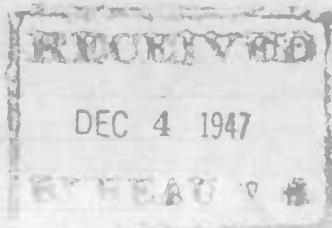
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 11-29-47Where did injury occur? near Laytonsville (City or town) Montgomery (County) Md. (State)Injured at home, farm, industry, public place (where?) highwayMeans of injury auto accident Injured at work? No23. SIGNATURE Frank J. Brothart M.D. M. D. or otherAddress Gaithersburg, Md. Date signed 11/29/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10213

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County, MontgomeryCity or town, Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 1 PM 11-24-47Hospital, institution, or street address where death occurred: Suburban Hosp8600 Old Georgetown Rd. Bethesda, Md.How long in hospital or institution? Since 1 PM. 11-24-47

3. (a) FULL NAME

Miss Mary Stout

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

FW

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age..... years

Sept. 8, 1928

8. AGE:

Years

Months

Days

If less than one day

..... hrs. min.

9. Birthplace

Viola, Kansas
(Town, county, and state)

10. Usual occupation

Clerk

11. Industry or business

12. Name

Charles Stout

13. Birthplace

Viola Kansas

14. Maiden name

Bernice Miller

15. Birthplace

Viola Kansas

16. Informant

Mrs Edwin B. Miller

Address

2913 1st Rd. N. Arlington Va.

17. Burial

BurialDate thereof 11/26/47
(month) (day) (year)

Cemetery or crematory

Location

Viola - Kans

18. Funeral director

The A. J. T. F. Co.

Address

2901-14th St. N.W. D.C.

19. Date rec'd by registrar

4/15/47

19. Date rec'd by registrar

19472pm 5 Jan

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C.

County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. McLean Gardens

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

November 25 1947 at 6:01 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

November 24 1947 to November 25 1947and that I last saw her alive on November 24 1947

Immediate cause of death

uremia acute

DURATION

2 daysDue to chronic Nephritis

15 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

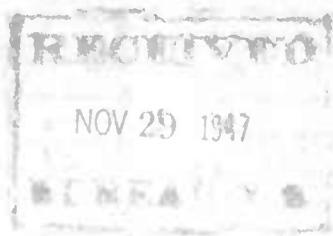
Injured at work?

23. SIGNATURE

Harry M Fletcher MD

M. D. or other

Address 3898 Potter St NW Washington D.C.Date signed 11-25-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94av

10214

216

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County MONTGOMERY

City or town BETHESDA

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 HR.

Hospital, institution, or street address where death occurred:

Suburban Hospital 8600 GEORGETOWN
BETHESDA MD.

How long in hospital or institution?

1 HOUR

3. (a) FULL NAME

MYRON STOUT

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MALE WHITE MARRIED

MARIO H. STOUT

6. (b) Name of husband or wife

6. (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.)

JANUARY 14, 1901

8. AGE:

Years 46

Months 10

Days 16

If less than one day

hrs.

min.

9. Birthplace

WASHINGTON, D.C.
(Town, county, and state)

10. Usual occupation

CLERK

11. Industry or business

Washington Board & Trust Co.

MOTHER FATHER

12. Name MYRON H. STOUT

13. Birthplace NEW YORK

14. Maiden name CLARINDA COURTE

15. Birthplace ILL.

16. Informant WIFE MRS. MYRON H STOUT

Address 1914 STRATTON Rd. Si. Spring, Md.

17. Burial

Date thereof Dec 3 1947
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory Cedar Hill

Location

Bethesda Md.

18. Funeral director

Joseph Hawley Sons

Address

1766 Penna Ave. N. W. Wash,

19. 12-2-47 19.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND

County

MONTGOMERY

City or town SILVER SPRING

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1914 STRATTON ROAD

(If rural, give LOCATION)

2.(a) If veteran, name war

NO.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30

1947 at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Syrup. Stake care

19.

to

19.

and that I last saw h alive on

19.

Immediate cause of death

Coronary accusion

Due to

DURATION

dead suddenly

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

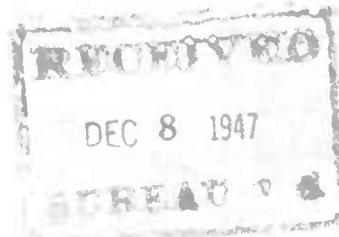
Means of injury

Injured at work?

23. SIGNATURE

Dr. J. Bressert M.D. M. D. or other

Address 1914 Stratton Road Date signed 11-30-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10215

Reg. Dist. No. 216

1. PLACE OF DEATH:

Montgomery
County.....

City or town..... Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 10-31-47

Hospital, Institution, or street address where death occurred: Suburban Hosp.

2600 Old Georgetown Rd. - Bethesda MD

How long in hospital or institution? Since 10-81-47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C.

County.....

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4629 - 49 First St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

George E. Stratton

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced

B. (b) Name of husband or wife: Claude P. Stratton - Dec

7. Birth date of deceased (mo., day, yr.) June 2, 1873

6. (c) If alive, give age years

8. AGE: Years 74 Months Days If less than one day hrs. min.

9. Birthplace: Buckland Mass.
(Town, county, and state)

10. Usual occupation: Civil Engineer

11. Industry or business

12. Name: Eber E. Stratton

13. Birthplace: Buckland Mass.

14. Maiden name: Electa Troubridge

15. Birthplace: Buckland Mass.

16. Informant: Miss Constance Stratton

Address 4629, 49 St N.W.

17. Burial, cremation, or removal: Removal Date thereof: 11/8/47

Cemetery or crematory: Arms Cemetery

Location: Hyllhurst Mass.

18. Funeral director: J. H. Hayes Co.

Address: 2901-14 Cast. D.C.

19. Date rec'd by registrar: 11-8 47 W.E. Gobea

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 1947 at 3:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 20 1947 to Nov. 8 1947 and that I last saw him alive on Nov. 7 1947

Immediate cause of death

Cerebral occlusion

Myocardial infarct

Due to Pulmonary congestion

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

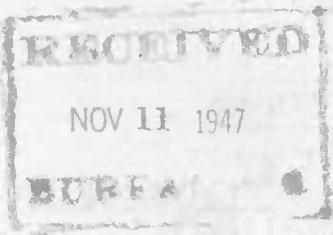
Injured at work?

23. SIGNATURE

P. P. Andrews M.D.

M.D. or other

Address: Washington, D.C. Date signed: 11-8-47



PLEASE WRITE **PLAINLY**, WITH UNFADING INK. Supply every item of information carefully. It is especially important. Physicians: please write the causes of death clearly and briefly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10216

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery.City or town Takoma Park, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/4 hrs.Hospital, Institution, or street address where death occurred: Washington San Ed Hosp.How long in hospital or institution? 39 2/3 hrs Ed 6 min.

3. (a) FULL NAME

Thomas Carl Katham

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White

8. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

November 5, 1947

8. AGE:

Years

Months

Days

If less than one day

15 8 hrs. 6 min.

9. Birthplace

Takoma Park, Montgomery Co. Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Charles Ephraim Calumnares Katham13. Birthplace Blk. 9, North Carolina14. Maiden name Father Elizabeth Ford15. Birthplace Washington D.C.16. Informant FatherAddress 90 Webster St N.E. Wash. D.C.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 8-1947

(month) (day) (year)

Cemetery or crematory Cedar Hill CemeteryLocation Prince George Co. Maryland18. Funeral director S. H. Hinnes CoAddress 2901-14th St. N.W. Wash. D.C.19. Reg'd. No. 7 1947

(Date rec'd by Registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of ColumbiaCity or town Washington D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 90 Webster N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6, 1947, at 8:15 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 5, 1947, to November 6, 1947, and that I last saw him alive on November 6, 1947.

Immediate cause of death

Patent Ductus Arteriosus
Patent Foramen Ovale

DURATION

lifetime
(39 hrs.)

Due to

Prematurity (5 weeks pre-mature)

Due to

Cesarian Section for pre-mature separation

Other conditions

of placenta in mother

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results see above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Katherine A. Chapman MD

M. D. or other

Address 29 West Baltimore St. Washington, Md. Date signed 11/6/47

RECORDED

NOV 10 1947

RECORDED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d
Reg. Dist. No. 3
10217

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

Montgomery

City or town.....

Spencerville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

50 yrs.

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

3. (a) FULL NAME

FRANCES EMMA THOMAS

4. Sex

F

5. Color or race

Col.

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife.....

George Thomas

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

June 23 1867

8. AGE:

Years

Months

Days

If less than one day

80

4

20

hrs. min.

9. Birthplace.....

Spencerville, Montgomery, Maryland

(Town, county, and state)

10. Usual occupation.....

none

11. Industry or business

12. Name.....

Tom Simpson

13. Birthplace.....

Spencerville, Md.

14. Maiden name.....

Margaret Mary Simpson

15. Birthplace.....

unknown

16. Informant.....

Edith Thomas

Address

Spencerville

17. Burial, cremation, or removal. Which?.....

Burial

Date thereof.....

Nov 17 1947
(month) (day) (year)

Cemetery or crematory.....

Mt. Calvary

Location.....

Spencerville, Md

18. Funeral director.....

R. L. Grindon

Address

Rockville, Md

19. Date rec'd by registrar.....

Nov. 17

(Date rec'd by registrar)

1947

Josephine Schaeffer
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

Montgomery

City or town.....

Spencerville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 13, 1947, at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1946 to November 1947

and that I last saw her alive on November 13 1947

Immediate cause of death.....

Bronchopneumonia

DURATION

Due to..... Hypertensive Heart Disease
with Decompensation

Due to.....

Other conditions..... Senility - Arthritis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

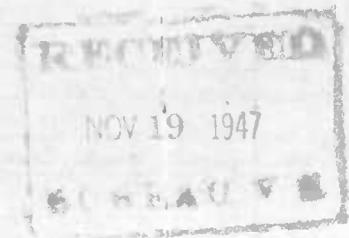
Means of injury.....

Injured at work?

23. SIGNATURE..... Richard A. Yates M.D.

M. D. or other

Address..... RFD #3 Rockville, Md Date signed 11/13/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10218

83b

Reg. Dist. No. 218

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Montg Co,
County Gaithersburg Md,
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Thomas Wilson Troxell

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife Minnie Faber Troxell

72

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) April 10 1875

8. AGE: Years Months Days if less than one day
1875 71 6 21 hrs. min.

9. Birthplace Emmittsburg Md Principals
(Town, county, and state)

Retired, Teacher

10. Usual occupation.

11. Industry or business James W Troxell

12. Name James W Troxell

13. Birthplace Md

MOTHER FATHER

14. Maiden name Mary E Zachariah

15. Birthplace Md

16. Informant Mrs Minnie Troxell
Address Gaithersburg Md,

Burial Burial Date thereof 11/3/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Forest Oak Cemetery
Location Gaithersburg Md,

18. Funeral director ERNEST C GARTNER
Address Gaithersburg Md,

VS A15 9-45-15M
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The date
is especially important. Physicians: please write the causes of death clearly and legibly.

19. M.D. 2 1947 Almada & Cooke
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Montgomery

City or town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1st 1947 at 3:15AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 29 1947 to Nov 1 1947

and that I last saw him alive on Oct 31 1947

Immediate cause of death Cerebral embolism

DURATION
3 days

Due to.

Due to.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J.J. Brochart M.D.

M. D. or other

Address Gaithersburg Md Date signed 11-1-47

RECEIVED

NOV 5 1947

BUREAU # 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10219

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County..... *Montgomery*
City or town..... *Bethesda*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

..... *Suburban Hospital*

How long in hospital or institution?

3. (a) FULL NAME

*Mr. Seldon Vaughan*4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Single*6. (b) Name of husband or wife *None*7. Birth date of deceased (mo., day, yr.) *Nov. 13, 1888.*8. AGE: Years *59* Months *0* Days *8* If less than one day *.hrs. .min.*9. Birthplace *West Virginia*

(Town, county, and state)

10. Usual occupation *Landscape work*

11. Industry or business

12. Name *Andrew Vaughan*13. Birthplace *West Virginia*14. Maiden name *Theresa George*15. Birthplace *West Virginia*16. Informant *self -*Address *Records Suburban Hospital*17. Removal-Transit Date thereof *Nov. 23, 1947*
(Burial, cremation, or removal. Which?) *(month) (day) (year)*Cemetery or crematory *Barnette Funeral Home*Location *Hinton, West Virginia*18. Funeral director *Wm. H. Seldon Humphrey*Address *Bethesda 14, Maryland*19. *11/2x 1947* *John S. Lawton M.D.*
(Date rec'd by registrar) *John S. Lawton M.D.* *Registrar*2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State *Maryland* County *Montgomery*City or town *Bethesda*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *-* (If rural, give LOCATION)2.(a) If veteran, name war *Unknown*

3. (b) Social Security Number

Unknown

MEDICAL CERTIFICATION

20. DATE OF DEATH *Nov. 21, 1947, at 7:50 P.M.*21. I CERTIFY that death occurred on the date above stated: that I attended deceased from *1947, to Nov. 21, 1947.*and that I last saw h.....alive on *1947.*Immediate cause of death *Heart failure*Due to *Hypertension**Heart failure*Due to *Hypertension**Heart failure*Other conditions *Hypertension*

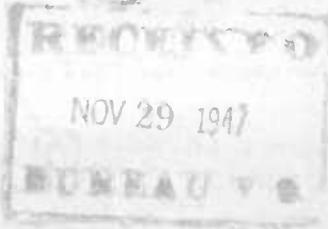
(Include pregnancy within 3 months of death)

Major findings or operations Date of op. Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury Injured at work? 23. SIGNATURE *John S. Lawton M.D.*M. D. or other Address *Suburban Hospital* Date signed *23 Nov. 47*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Check each age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

77c

CERTIFICATE OF DEATH

10220214
Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Montgomery
Silver Spring

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

died wrote to Cedarcroft san.

How long in hospital or institution?.....

3. (a) FULL NAME

George N. Walker

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

married

6.(b) Name of husband or wife

Margolin Walker

6.(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.)

Aug 17 1899

8. AGE: Years

74 2 19

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Washington, DC.

(Town, county, and state)

10. Usual occupation

Ex sec laundry & dry clean work

11. Industry or business

Laundry

MOTHER FATHER

12. Name.....

Frank Walker

13. Birthplace

DC

14. Maiden name

Otilia J. Stummel

15. Birthplace

Newark, N.J.

16. Informant

Margolin Walker

Address 1324 Ingram st DC

17. REMOVAL

(Burial, cremation, removal. Which?) Date thereof Nov 7-96

Cemetery or crematory Rock Creek Cemetery

Location Work DC

18. Funeral director

THE S.H. HINES

Address 2981-14-57 46

19. Nov. 7

(Date rec'd by registrar) 1947

Josephine Schaeffer

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

DC

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1324

Ingram st n. w

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1947 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med Exam to t9. and that I last saw h. alive on t9.

Immediate cause of death.

Cerebral edema

DURATION

Due to.

Due to.

Other conditions.

Acute alcoholism

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results. Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Buschart M.D. M. D. or other

Address Gaithersburg Md. Date signed 11-6-47

RECEIVED

NOV 8 1947

BUREAU # 8

LAW # 345
P. 100-11892

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10221

940

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery
City or town Silver Springs

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Clarence J. Warnick

4. Sex Male | 5. Color or race White | 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Nelle Lee Warnick

7. Birth date of deceased (mo., day, yr.) May 7, 1885 | 6. (c) If alive, give age years

8. AGE: Years 62 | Months 6 | Days 1 | If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Oil Burner Business

11. Industry or business

12. Name Charles Warnick

13. Birthplace Maryland

14. Maiden name Katherine Otto

15. Birthplace Maryland

16. Informant Don Warnick

Address Manhasset, N. Y.

17. Burial Date thereof Nov. 12, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Prince Georges Co., Md.

18. Funeral director John Lee Sons Co.

Address 300 4th. St. N. E. Washington, D.

19. Nov. 10 1947 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Springs
(If outside city or town limits, write RURAL and give nearest town)Street No. 2011 Luray & Bowie Way
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1947 at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... Nov. 12, 1947

and that I last saw him alive on.....

Immediate cause of death

Coronary Thrombosis

DURATION
1 hour

Due to..... Coronary sclerosis ?

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

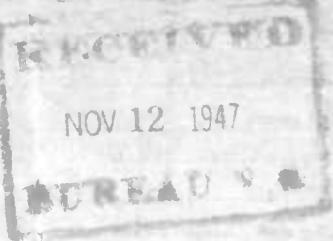
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

C. 23. SIGNATURE William D. Amd mD M. D. or other

Address 9006 Colenwth Rd., Silver Spring, Date signed Nov. 17



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10222
94a

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:
County Montgomery
City or town Etchison
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs.
Hospital, institution, or street address where death occurred:
None
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Etchison
(If outside city or town limits, write RURAL and give nearest town)
Street No. None
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME
***** JOHN BAPTIST WATERS

3. (b) Social Security Number
***** None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Mary Ray Waters

7. Birth date of deceased (mo., day, yr.) December 27, 1880

8. AGE: Years Months Days If less than one day
66 66 10 8 - hrs. - min.

9. Birthplace Jersey City, N. J.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farming

FATHER 12. Name John Waters

MOTHER 13. Birthplace Ireland

14. Maiden name Elizabeth Smith

15. Birthplace Ireland

16. Informant Mrs. Mary Ray Waters

Address Etchison, Maryland

17. Burial Date thereof November 6/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Grace Episcopal Church Cem.

Location Woodside, Maryland

18. Funeral director Wm. T. Anderson Pumphrey

Address Bethesda, Maryland

19. 10/16 19. 4/7 Absent G. S. Corle
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4, 1947 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18, 1947, to November 4, 1947, and that I last saw him alive on November 4, 1947.

Immediate cause of death Coronary occlusion

Due to Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

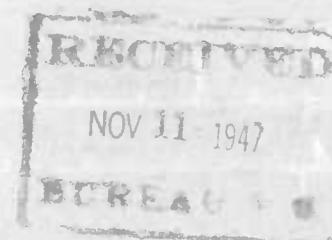
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE James D. Kerr M.D. M. D. or other

Address 1000 N. Charles St., Md. Date signed 11/3/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11454

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County... Montgomery

City or town... Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution?

3. (a) FULL NAME

Gerald Marvin Wessel

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Single

B. (b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.)

November 26, 1847

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

1

hrs.

min.

9. Birthplace

Olney, Montgomery Co., Maryland.

(Town, county, and state)

10. Usual occupation

Inxart.

11. Industry or business

12. Name... Roland Frederick Wessel

13. Birthplace Fulton, Maryland.

14. Maiden name Dorothy Elizabeth Hatley

15. Birthplace Laurel, Maryland

16. Informant Hospital records

Address St. Paul Co Hospital

17. (Burial, cremation, or removal. Which?) Date thereof Nov. 29 - 1947

(month) (day) (year)

Cemetery or crematory

Burial St Paul Fulton Md

Location

Fulton 2nd

18. Funeral director De Witt Woodward

Address

Laurel Md

Dec. 1, 1947

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland

County... Howard

City or town... Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No. Star Route

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1947 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 26 1947, to Nov. 27 1947

and that I last saw h.r.m. alive on November 27 1947

Immediate cause of death Aspergillosis

Pneumonia

DURATION

12 days

Due to Aspergillosis

Vomited & aspirated

Due to vomitus

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

JMB/1 M. D. or other

Address Sandy Spring Date signed 11/27/47

(Data rec'd by registrar)

RECEIVED

DEC 22 1947

ST REAGAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Inexact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

161a

102223

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 min.

Hospital, Institution, or street address where death occurred:

Washington Sanitarium + Hosp.How long in hospital or institution? 34 min.

3. (a) FULL NAME

Unnamed Baby Westbury

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Fe white —

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) November 28, 1947

6. (c) If alive, give age years

8. AGE: Years — Months — Days — If less than one day hrs. 34 min.9. Birthplace Takoma Park Md.
(Town, county, and state)10. Usual occupation —11. Industry or business —12. Name Westbury Vincent Brox13. Birthplace Waukegan Illinois14. Maiden name Perrin Gladys Jane15. Birthplace Ethel Missouri16. Informant Washington Sanitarium RecordAddress Takoma Park Md.17. Burial Burial Date thereof Nov. 29, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Ges. Washington Mem. CemeteryLocation Kings Rd., Hyattsville Md.18. Funeral director J. Leibman WaltersAddress 254 Claude St. Mt. Phil. Md.19. Nov. 29, 1947 J. Leibman Walters

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn, infants give residence of mother)

State Maryland County MontgomeryCity or town Takoma Park (If outside city or town limits, write RURAL and give nearest town)Street No. 915 Garland Ave. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH November 28, 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

11-28-1947, 10. 11-28-1947

and that I last saw her alive on 11-28-1947

Immediate cause of death Atelectasis lungs in new bornDue to cause unknownDue to —Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —Autopsy results as above Date of op. —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) — (County) — (State) —Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE Emma Hughes M.D.

M.D. or other

Address Takoma Park Md. Date signed 11-28-47

Registrar

RECEIVED

DEC 3 1947

SCHEAVERS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age.
is especially important. Physicians; please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH X

2411 N. Charles St., Baltimore

10224
55a

CERTIFICATE OF DEATH

Reg. Dlat. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 months 21 days

Hospital, Institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 8 months, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

State Maryland County

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 403 Hilton Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war. WW II

3. (a) FULL NAME

WHITELEY, Benjamin (nm) Jr.

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

single

6.(b) Name of husband or wife

Mr. Benjamin Whiteley

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

20 May 1926

8. AGE:

Years Months Days It less than one day
21 6 1 hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

U. S. Navy

11. Industry or business

12. Name Benjamin Whiteley Sr.

13. Birthplace Maryland

14. Maiden name Clarita Dalcourt

15. Birthplace Maryland

16. Informant U. S. Naval Records

Address

17. burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 23, 1947
(month) (day) (year)

Cemetery or crematory Loudon Park Cemetery

Location Baltimore, Maryland

18. Funeral director W. W. Chambers Co. E.S.

Address 1400 Chapin St., NW, Washington, D.C.

19. 11-22 1947
(Date rec'd by registrar)

Mary C. Patterson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 November 1947 at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
4-1- 1947 to 11-21- 1947

and that I last saw h. im. alive on 11-21- 1947

Immediate cause of death Rhabdomyosarcoma of the

st. feet with wide spread
metastasis

DURATION

8 mo.

Due to.

Due to.

Other conditions Bronchitis pneumonia

(Include pregnancy within 8 months of death)

Major findings of operations Rhabdomyosarcoma a foot -
amputation foot Date of op. April 4, 1947

Autopsy results Wide spread metastasis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

W. P. HORTON, LTJG MC USNR

M. D. or other

Address USNH, Bethesda, Maryland Date signed 11-22-47

RECEIVED

DEC 3 1947

FBI - BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If no correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10225
117a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County.....
MontgomeryCity or town.....
Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

8 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

8 days

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... D.C.

County.....

Washington, D.C.

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No. 938 Shepard St., N.W.

(If rural, give LOCATION)

Sp.Am. & WWI

2.(a) If veteran, name war.....

3. (a) FULL NAME

WILLIAMS, John Benjamin

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo. day yr.) November 5, 1873

8. AGE: Years	Months	Days	If less than one day
74	0	22	hrs. min.

9. Birthplace.....
(Town, county, and state)Penn.
retired

10. Usual occupation.....

11. Industry or business.....

12. Name..... WILLIAMS, Benoni dec.

13. Birthplace..... Pa.

14. Maiden name..... SIMPSON, Mary Jane dec.

15. Birthplace..... Pa.

16. Informant..... daughter: Mrs. Lenora Howe.

Address 238 Shepard St., N.W., Wash., D.C.

12-1-47

17. burial..... Date thereof..... (month) (day) (year)

(Burial, cremation, or removal. Which?) Cemetery or crematory.....

Cemetery or crematory..... Location.....

Arlington, Va.

18. Funeral director..... W. W. CHAMBERS

Address 1400 Chapin St., N.W., Wash., D.C.

19. 11-28 19 47
(Date rec'd by registrar)Mary C. Patterson
Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... November 27 19 47 at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 November 19 47 to 27 November 19 47

and that I last saw him alive on 27 November 19 47

Immediate cause of death..... Gastric - Intestine hemorrhage

DURATION..... opened days

Due to..... perforated peptic ulcer 2 days

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... confirmed above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

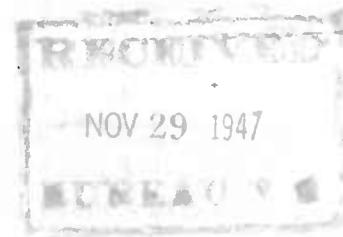
Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work?

23. SIGNATURE..... W. R. TRUE, Lt. JG MC USNR
M. D. or other

Address..... USNH Bethesda, Md.

Date signed..... 11-28-47





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10226

13/la

CERTIFICATE OF DEATH

216

Reg. Dist. No.

1. PLACE OF DEATH:

Montgomery

County.....

Bethesda (rural)

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 mons. 7 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?..... 2 mons. 7 days

3. (a) FULL NAME

WILSON, Harry Macon

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

W-US

married

6.(b) Name of husband or wife

Myrtle Wilson

7. Birth date of deceased (mo., day, yr.)

November 26, 1877

6.(c) If alive, give age..... years

8. AGE:

Years
69Months
11Days
11

If less than one day

hrs.

min.

9. Birthplace.....

Virginia

(Town, county, and state)

10. Usual occupation

Retired - U.S. Naval Gun Factory

11. Industry or business

Washington, D.C.

MOTHER FATHER

12. Name.....

Wilson, Erick d.c.

13. Birthplace.....

Virginia

14. Maiden name.....

Baskett, Sueanna dec.

15. Birthplace.....

Virginia

16. Informant.....

wife: Mrs. Myrtle Wilson

Address.....

829 20th St., So., Arlington, Va.

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Arlington National

Location.....

Arlington, Va.

18. Funeral director.....

Wheatley Funeral Home

Address.....

Alexandria, Va.

19. (Date rec'd by registrar)

11-7-47

19.

Mary C. Patterson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Arlington

State..... Va.

County.....

City or town..... Arlington

(If outside city or town limits, write RURAL and give nearest town)

Street No.

829 20th St., So.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

WWI

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

November 17

1947

at 2:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 30, 1947, to Nov. 17, 1947

and that I last saw h.im alive on 7 Nov. 1947

Immediate cause of death

Coronary Thrombosis

DURATION

48 hrs

Generalized and Coronary
atherosclerosis

? years

Hypertensive cardio-vascular
retinal disease

? years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. G. Messerschmidt M. D. *H. G. Messerschmidt*

Loyalty Ass'n 15th Street, N.W. Date signed Nov 7, 1947

Address: 15th Street, N.W. Date signed Nov 7, 1947

RECEIVED

NOV 14 1947

FEDERAL BUREAU OF INVESTIGATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10227
131a
f18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Montgomery
 City or town RURAL - Brooksville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs.

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution? _____

3. (a) FULL NAME

Sarah McKhemery WILSON

4. Sex F Color or race Wh Widowed

5. (a) Single, married, widowed, or divorced

B. (b) Name of husband or wife David F. Wilson

7. Birth date of deceased (mo., day, yr.) July 26, 1865

8. AGE: Years Months Days If less than one day

82 4 4 hrs. min.

9. Birthplace Charles town W. Va.

(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name John Wesley Ashby

13. Birthplace Ireland

14. Maiden name Susan Ware

15. Birthplace Virginia

16. Informant David F. Wilson

Address Brooksville Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Dec 9, 1947

(month) (day) (year)

Cemetery or cemetery Pleasant Hill

Location Farmstown Long Kelly Farm

18. Funeral director Rev W. Barker

Address Brooksville Md.

19. (Date rec'd by registrar) 12/1/47

(Date rec'd by registrar) 12/1/47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montgomery
 City or town RURAL - Brooksville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war: _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 1947, at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1946 to Nov. 30, 1947

and that I last saw h. e. alive on Nov. 27, 1947

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to Essential Hypertension

years

Due to Hypertensive Cardio-vascular Disease

years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

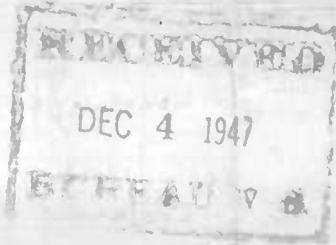
Injured at home, farm, industry, public place (where?) Injured at work?

Means of injury Injured at work?

23. SIGNATURE Richard A. Yates M.D.

M. D. or other

Address RFDA #3 Rockville Md. Date signed 11/30/47



PLEASE WRITE PLAINLY, WHICH UNFADING INK. Supply every item of information exactly. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10225

93d

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

4 days

How long in above place of death?

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution?

4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

D. C.

County.....

Washington

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

3919 R Street, Southeast

(If rural, give LOCATION)

2.(a) If veteran, name war..... WW I

3. (a) FULL NAME

WINGO, Clyde Arlington

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

8.(b) Name of husband or wife..... Mrs. Jenny Wingo

7. Birth date of deceased (mo., day, yr.)..... 8.(e) If alive, give age..... years
16 June 18958. AGE: Years Months Days It less than one day
52 4 22 hrs. min.9. Birthplace..... Virginia
(town, county, and state)

10. Usual occupation..... Special Agent

11. Industry or business..... Southern Railway

12. Name..... Floyd J. Wingo

13. Birthplace..... Virginia, deceased

14. Maiden name..... Cora Green

15. Birthplace..... Virginia, deceased

16. Informant..... Wife: Mrs. Jenny Wingo

Address..... 3919 R St., SE, Washington, D. C.

17. Burial..... Date thereof..... (month) (day) (year)
(Burial; cremation; or removal; which?)

Cemetery or crematory..... Oakwood Cemetery

Location..... Richmond, Virginia

18. Funeral director..... S. H. Hines Funeral Co. Ltd.

Address..... 2901 14th St. NW, Washington, D. C.

19. 11-8 19-47 Mary C. Patterson
(Date record by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 7 November 10 47 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
11-3- 10 47 11-7- 10 47

and that I last saw her alive on 11-7- 10 47

Immediate cause of death:

Sudden coronary occlusion

DURATION

4-5 min

Due to: Coronary Heart Disease
Arteriosclerosis

4-5 yrs

Due to:

Other conditions: Myocarditis
Anterior. Old Cerebral Thrombosis 10 yrs +
(Include pregnancy within 3 months of death)

1 yr.

Major findings or operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (city or town) (county) (state)

Injured at home, farm, industry, public place (where?)

Means of injury:

Injured at work?

23. SIGNATURE

Hugh Stevens Jr. M.D.

M. D. # 87865

Date signed 11-8-17

RECEIVED

NOV 14 1947

BUREAU V